



States of Guernsey
Children and Family
Community Services

Assessments Guidance

**Including additional guidance due to the
particular needs of the child or specialist detail
required for the assessment**

Contents

1. Principles and Parameters of a good assessment	3
2. Children in Need	4
3. Ten pitfalls in assessment and how to avoid them	6
4. The Stepwise Approach	7
Hypothesising	9
Planning	13
Gathering Information	18
Testing and Evaluating	20
Analysis	22
Decide Plan	28
Review	29
Risk Assessment Tools	
5. Risk and Resilience Model	30
6. Paul Brearley: Hazards, Dangers and Protective Factors	44
7. Neglect and Emotional Abuse	47
8. Child Sexual Exploitation	48
9. Child has additional needs due to disability or a complex health condition	50
10. Domestic Violence	59
Assessment and Intervention with domestically violent men	62
11. Pre-birth Assessment	64
12. Assessment of Perpetrator of Child Sexual Abuse	
Finkelhor's Model	68
13. Ward's Pathway Model	75
14. Harmful Sexual behaviours in Children and Young People	86
13. Assessing Vulnerable Adults and Parents with Learning Disabilities	101

The principles and parameters of a good assessment

Assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child from within and outside their family. It is important that the impact of what is happening to a child is clearly identified and that information is gathered, recorded and checked systematically, and discussed with the child and their parents/carers where appropriate.

Good assessments support practitioners to understand whether a child has needs relating to their care or a disability and/or is suffering or likely to suffer significant harm.

High quality assessments:

- are child-centred, be rooted in child development: be age-appropriate; and be informed by evidence
- fully consider the ethnicity and identity of children and take into account the child's history
- are focused on action and outcomes for children
- are holistic in approach, addressing the child's needs within their family and any risks the child faces from within the wider community
- demonstrate a clear analysis of findings
- are shared with families in a format and language that they can understand
- ensure equality of opportunity
- involve children, ensuring that their voice is heard and provide appropriate support to enable this where the child has specific communication needs
- involve families
- identify risks to the safety and welfare of children
- build on strengths as well as identifying difficulties
- are integrated in approach
- are multi-agency and multi-disciplinary
- are a continuing process, not an event
- lead to action, including the provision of services
- review services provided on an ongoing basis
- are transparent and open to challenge

Children in Need

All children who are in need as defined by the Children Law 2008 will have some needs which require assessment and potential support and those needs should be analysed within this model. Needs may also include needs for protection, and where these are identified, at any stage in an assessment process, the risk assessment tools outlined below must be used.

Needs assessment must also focus on this specific child's needs in these specific circumstances - they should not be couched in terms of services, or generalised statements such as 'needs to be safe, to achieve etc.'" Intervention and support must focus on more specific, localised needs which will identify and build on the strengths and protective factors already present in *this* family and community network, and which will eventually enable *this* child to achieve good outcomes with the support of universal services.

For example, the child may have developmental and speech delay. Their *needs* are not necessarily for speech and language therapy, but are to be able to communicate with adults and peers. This can be achieved in a number of ways which might include speech therapy, but might not! Quality time with parents may suffice together with support for parents in reading and talking to their child.

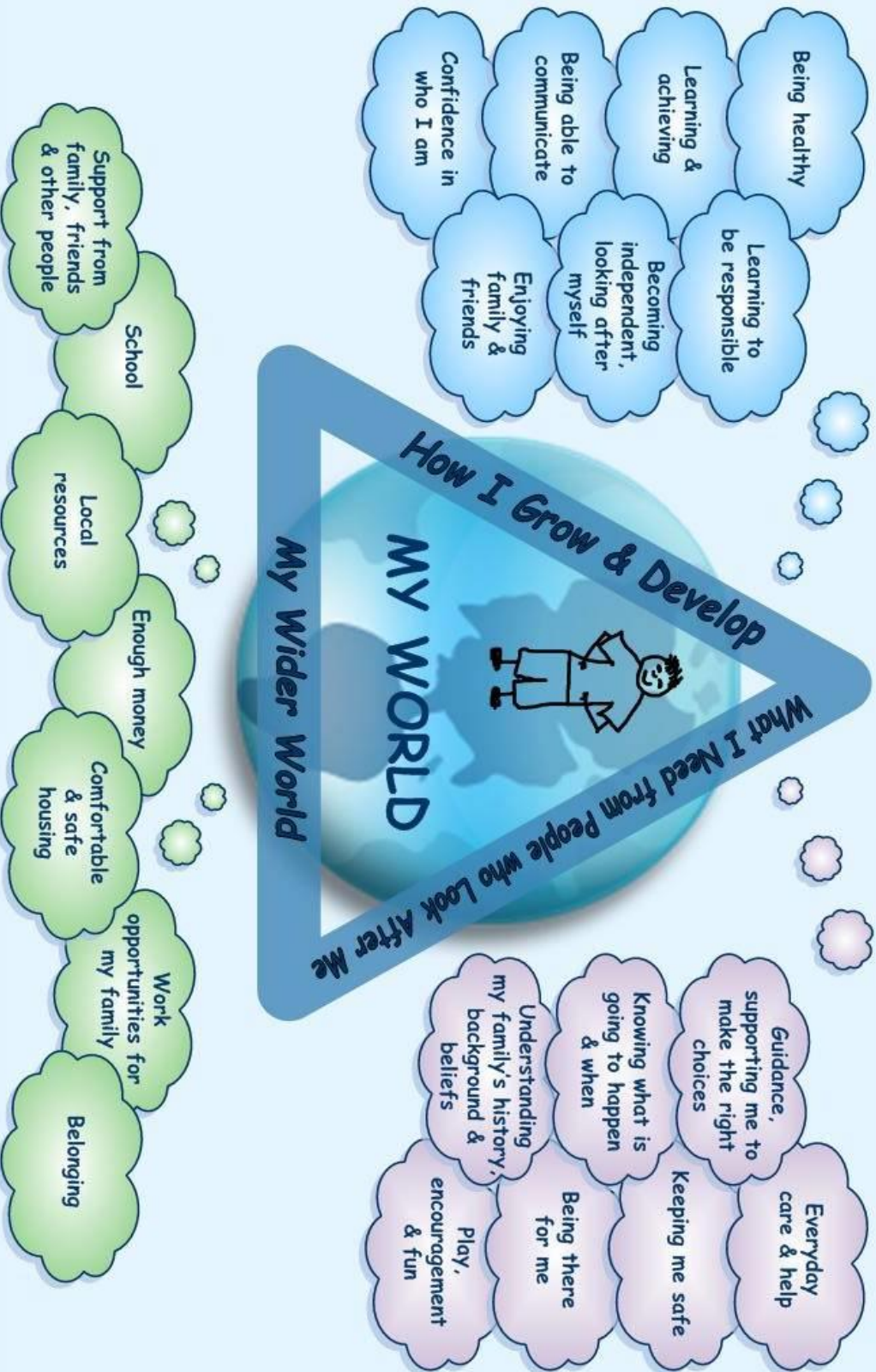
Research is continuing into what make some people, including children, able to weather adversity and misfortune while others become hurt and damaged by the same experiences. This has led to the concept of 'resilience' as a key characteristic which can be identified and developed in children, and in their support networks, to ensure that they have the best possible life chances. The "International Resilience Project" used the following definition:

"Resilience is a universal capacity which allows a person, group or community to prevent, minimise or overcome the damaging effects of adversity".

The following act as useful indicators of vulnerability and resilience in terms of the 3 domains of the *Getting it Right for Every Child, My World Triangle*; how I grow and develop, my wider world and what I need from people who look after me.

My World Triangle

getting it right for every child



The whole child or young person: Physical, Social, Educational, Emotional, Spiritual & Psychological development

Ten pitfalls in assessment and how to avoid them	
Pitfalls	Strategies to avoid the pitfalls
1. An initial hypothesis is formulated on the basis of incomplete information, and is assessed and accepted too quickly. Practitioners become committed to this hypothesis and do not seek out information that may disconfirm or refute it.	Active, conscious hypothesising, testing to confirm/disconfirm Record uncertainties Critical reflection Evaluate the quality & source of information
2. Information taken at the first enquiry is not adequately recorded, facts are not checked and there is a failure to feedback the outcome to the referrer.	Go back to the referrer and check the details, distinguish between observation & opinion, ensure that the information has been accurately understood, ensure referrers receive feedback
3. Attention is focused on the most visible or pressing problems; case history and less “obvious” details are insufficiently explored.	Consider the context and the chronology Theme the chronology Summarise the chronology eg, 0-5, 6-11,12-16, 16 + Put the child’s voice into the chronology Use the chronology for analysis
4. Insufficient weight is given to information from family, friends and neighbours.	Give equal weight to referrals from family, friends & neighbours Ensure that “anonymous” is not interpreted as “malicious”
5. Insufficient attention is paid to what children say, how they look and how they behave.	Clearly understand the legal framework for seeing the child Be alert to the need to recognise patterns of parental resistance Make time for detailed direct observations of the child Find out from the child what a day in their life is like Consider how the child may be silenced by their circumstances
6. There is insufficient full engagement with parents (mothers/fathers/other family carers) to assess risk.	Dads! Dads! Dads! And other family members Engagement & honesty Understand the reasons and meaning of “lack of engagement” for individual families Use a clear framework to assess & analyse risk

<p>7. Initial decisions that are overly focused on age categories of children can result in older children being left in situations of unacceptable risk.</p>	<p>Know that children’s services are biased towards intervening with younger children Respond robustly to “hard to help” neglected adolescents Monitor self & others for “over optimism” with older children Find out from the child what a day in their life is like Ask, if this child were younger, how would we respond?</p>
<p>8. There is insufficient support/supervision to enable practitioners to work effectively with service users who are uncooperative, ambivalent, confrontational, avoidant or aggressive.</p>	<p>Pay attention to how you feel, notice fear, anxiety, avoidance in yourself Demand quality supervision Have a clear strategy to keep you & others safe in vulnerable situations Joint Visits with other agencies Speak up when you feel fearful, threatened, intimidated: it is a sign of an effective practitioner</p>
<p>9. Throughout the initial assessment process, professionals do not clearly check that others have understood their communication. There is an assumption that information shared is information understood.</p>	<p>Check out how information has been received and understood When talking to other professionals, be curious about what they think and feel and how they understand the situation Be mindful of the desire of some people to deceive – maintain a “respectful uncertainty” & “healthy scepticism”</p>
<p>10. Case responsibility is diluted in the context of multi-agency working, impacting both on referrals and response. The local authority may inappropriately signpost families to other agencies, with no follow up.</p>	<p>Role Clarity Effective communication with other agencies, maximise verbal & face to face communication Confirm key decisions & reasons in writing</p>

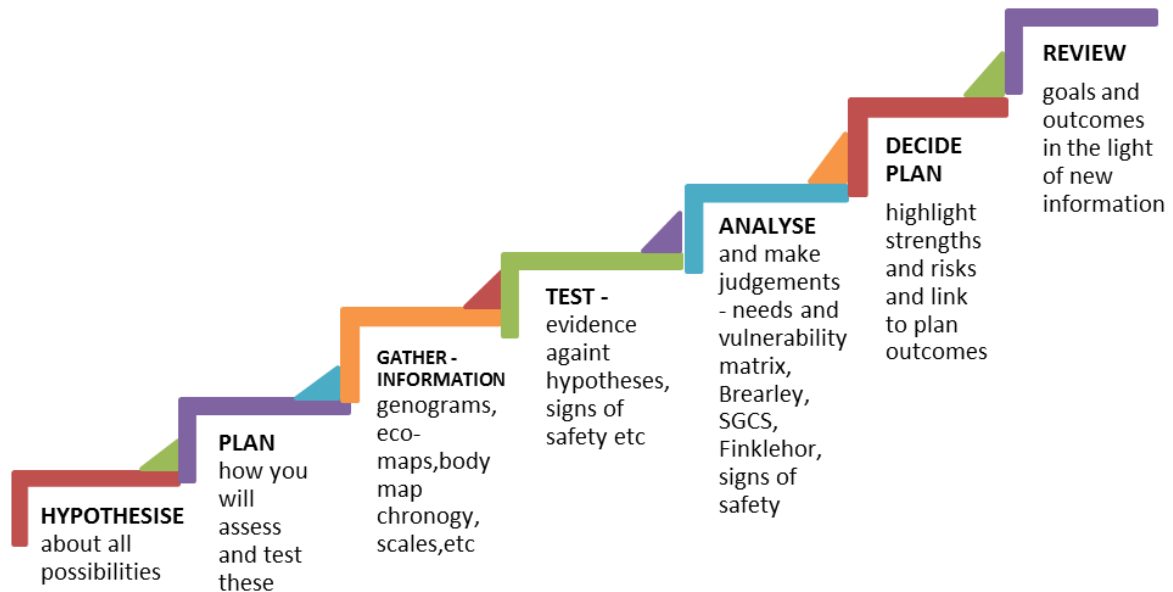
Broadhurst et al 2010,

The STEPWISE Approach

"Stepwise" is an approach based on work by Eric DeMello and John Yuille. This requires a structured approach that any assessment team will need to follow to produce an effective assessment of needs and risks and a plan that positively manages risks and meets the identified needs in a way which is appropriate to the individual child and family concerned.

The use of the term 'team' refers to the professionals and the family members who will together carry out the assessment and then implement the plan, together with the family and family network. It also includes the social work manager who must ensure that the assessment and plan are sufficient to manage the identified risks to the child concerned, and to meet their needs. Supervision is a key tool in which each of the steps can be evaluated, hypotheses discussed, and evidence tested.

Where risks or needs are immediate these steps can be taken very quickly in order to secure the immediate safety of the child, which must take priority. The steps then provide a structure for reflection and proper analysis leading to an effective longer term plan.



Step One: Hypothesis

Forming hypotheses

The process of forming and testing hypotheses starts from the first moment of contact between the practitioner and family. Hypothesis can be conscious or subconscious. When testing hypotheses practitioner must look for the exceptions (times or people which do not fit with the practitioner's theory); this avoids practitioners picking information which verifies their hypotheses or generalising too broadly. In the complex situations typical of social work practice, there will almost always be more than one reasonable hypothesis to explain what is known and it is important to recognise this and to explicitly record what hypotheses have been considered and why.

Hypothesising involves thinking about what you know and generating plausible ideas to explain it. Hypothesising is not about being right or finding the correct explanation but rather offers a way to be curious, opening up new lines of enquiry, new ways of thinking and new ways of working. (David Wilkins, 2016, Community Care Inform).

As hypotheses are generated, it is important to consider what information would falsify or disprove each one (how each one could be tested). All of us have a tendency to seek out information to confirm our beliefs (confirmation bias) and so we need to work extra hard and explicitly so in order to seek out information that might disconfirm what we think.

It is imperative to use a wide variety of tools to gather information: interviewing parents; interviewing professionals; direct observations; using questionnaires and scales; creative approaches for engaging children; making reference to research and theory.

Testing and evaluating hypotheses is a key part of the assessment process; those that have not been tested during an initial assessment may indicate that a core assessment is necessary.

How to Hypothesise

- Write down explanations or insights that are presented to you
- Next to each explanation write down how you could test it

The word *hypothesis* has its origins in ancient Greek and means '*a proposed explanation for a phenomenon*' (Wikipedia - online dictionary). In modern day usage, a hypothesis is a provisional idea or explanation which has to be evaluated or tested. The idea needs to be either confirmed or disproved. The hypothesis should be 'falsifiable', which means it is

possible for it to be shown to be false, usually by observation. Even if confirmed, the hypothesis is not necessarily proven, but remains provisional.

Hypothesising is a core activity within social work assessment. Holland (2004) states:

"The cornerstone of analysis in assessment work might be seen as the process of building hypotheses for understanding a family situation and developing these until they include a plan for the way forward."

This process of building, testing out and discarding hypotheses starts at the earliest point of contact. As soon as a referral is received into a social work team the practitioner will begin consciously or unconsciously to form some hypotheses of what is happening within the family. They would certainly check out some of their hypotheses during an initial conversation with the referrer and may even ditch one or more of them at this stage. The formation of various hypotheses and the decision taken about the steps needed to investigate the matter further will be influenced by a range of factors, for example: practice wisdom, personal values, and formal knowledge.

Munro highlights the fact that *"The single most important factor in minimizing errors (in child protection practice) is to admit that you may be wrong"* (Munro 2008: 125).

In risk assessment Raynes in Calder and others (2003) suggests that workers often remain narrowly focused on proving or disproving whether the original risk or perception about a family remains and fail to consider the broader picture, or alternative hypotheses about what is happening and why. Practitioners should therefore consider **all** the possibilities about what is happening and address each hypothesis, only discarding it when there is clear evidence to do so.

Stepwise requires that this is considered as part of a structured approach and that forming, testing out and discarding hypotheses needs to be a clear and recorded part of any assessment process.

Questions for Hypothesising and Reviewing Hypotheses

The intention is that these questions are used as triggers to help practitioners reflect on whether they have explored all possible hypotheses during an assessment and have explained this thoroughly in their assessment report.

1. Hypothesising at the Early Stage of Involvement

- Can you develop some hypotheses - at least four? (More if you can – keep them broad, not just single-incident based ones.)
- What knowledge and information are the hypotheses based on (for example, theory, research, observation, assumptions, information given, and hearsay)?
- What actions could you take to test out your hypotheses?
- Can you construct an action plan for testing them, with timescales identifying the methods you will use?
- Who will be involved in gathering information to test out your hypotheses?
- How will you seek evidence to disprove (disconfirm) your hypotheses?
- What will you use to help you decide how to weight the value of different hypotheses?

2. Reviewing hypotheses Mid-Way through on Assessment

- Have you been able to test out all of the original hypotheses?
- Are you satisfied that you have tested the hypotheses rigorously and you haven't simply sought out information to confirm your original hypotheses?
- Of the original hypotheses, which have you discarded and why?
- Have any new hypotheses emerged?
- What methods are you going to use to test out the new hypotheses?

3. Evaluating hypotheses Towards the End of the Assessment

- Are you satisfied that you have tested all the available hypotheses sufficiently rigorously?
- Are you able to demonstrate, in your assessment report, the methods you have used to test out the hypotheses and why you have discarded or retained each one?
- Are there some hypotheses that you have not been able to test out because of the unavailability of sufficient information or lack of time or access to key people?
- If so, are further enquiries indicated beyond the point of this assessment?
- If so, what form do you recommend these should take?

In essence, at this step, practitioners should be asking: *"What are we worried about? What is the possible danger or harm to the child?" If our hypotheses are correct, what needs to happen?"*

Where hypotheses relate to actual or likely abuse of a child, the child protection procedures must be followed, and the assessment planned as part of a strategy discussion or meeting.

Hypothesising exemplar

Hypotheses	Methods for testing Hypotheses
Domestic violence	Ask each parent, alone, physical evidence? Talk to older children, check with Police and other agencies, investigate previous relationships, talk to extended family
Overlay is a possibility	Check the sleeping arrangements, temperature of the room, parent's understanding. Parent's capacity for rational actions at all times
The parent's histories are affecting their parenting	Take a full history from parents, grandparents and check out facts with agencies where possible
Some other possible hypotheses	
There is likely drug/alcohol abuse	Ask parents, ask others, and check for involvement with substance misuse services, check with police, and check with grandparents/neighbours. Use the SCODA assessment framework
There might be attachment issues with baby	Careful, assessment of parents' understanding of baby's needs, do they understand the baby as having separate needs? Do they respond consistently to expressions of need? Use Fahlberg checklists
Neglect might be happening	Check baby's physical presentation, check food and hygiene in the home, check stimulation for baby/child(ren), use graded care profile
Mum is depressed (post natal depression)?	You can use DOH adult wellbeing scale or other similar, ask mum, liaise with other agencies
Financial difficulties, impact of poverty	Talk to parents, look at financial information, check benefits take-up/entitlements
On the run from a CP plan in another authority	Check with agencies and authorities

Step Two: Plan

All assessments require planning, which addresses how the assessment will be conducted. This includes agreement not just on how workers will assess the family but also how they will work together effectively with others. Workers tend to concentrate on the tasks they need to undertake in respect of the child and the family, but spend little time considering how they will maximise the combined skills and knowledge of other agencies, and how they can support and complement one another's work. Assessments should be multi agency, and should draw on the information held elsewhere, and on the child's records, if these already exist.

Understanding the impact of current concerns and risks must include an understanding of the history and therefore the significance of current events in the child's life experience. Building and accessing a good chronology, and using this to inform current analysis is central to good risk assessment.

Planning for the assessment must relate to the working hypotheses identified in step one, and identify what information must be collected to disprove or evidence the validity of one or more of these. Planning in itself, with other professionals may lead to one or more of these being discarded and at the next step it will be important to clearly identify for parents and other professionals what working hypotheses are now being explored. For example, in relation to suspected or alleged sexual abuse, the hypotheses may include:

The child is being sexually abused by X - or by someone else

The child (or someone else) has said or done something which is being misinterpreted

There is inappropriate handling or poor boundaries

The child is experiencing other forms of abuse or difficulties

The assessment will then need to focus on what information is needed to test out these hypotheses, and given that it is potentially a child protection issue, this will need to be planned via a strategy discussion unless initial enquiries at the referral stage clearly evidence that the sexual abuse hypotheses are not valid. Child protection procedures should be considered.

Where the child protection hypotheses are validated, or cannot be discarded as a result of initial assessment and action, following the step wise approach, an initial safety plan must be put in place for the child up to and including the convention of a child protection conference. The risk assessment tools outlined in the analysis step should be used to underpin this.

Where the child is subsequently made subject to a child protection plan, risk assessment and action is managed through the core group. The initial child protection conference should determine the overarching plan, and the core group will take this forward, ensuring that risks continue to be evaluated and the impact on the child assessed as the plan develops and is reviewed.

Timescales

Everyone involved, including the family, should be clear about how long an assessment will take and what is expected of them at different stages. The following factors should underpin all decisions in this planning stage:

- *Decisions about the child should not be unnecessarily delayed and immediate risks must be acted on in a proportionate manner*
- *The family will feel more empowered if they have a clear understanding of the time parameters and when decisions are likely to be taken*
- *Professionals contributing to the assessment and management of identified risks need to be clear about how long they have for information gathering, when and where to provide information and when and how this will be evaluated*

Where the primary purpose of the assessment is risk assessment, the time scales will be dictated by the child protection process and reference should be made to the child protection procedures.

Where the focus is on needs assessment and danger or risk of significant harm to the child has not been identified as an issue, the timescale will be identified by the team around the child, in agreement with the family and the social work team manager.

Evaluating parenting skills

It is important that the family and the professionals involved in the assessment know what indicators will be used to evaluate the family i.e. what is a reasonable level of parenting for the children in this particular family and how this will be measured. The use of the tools underpinning this framework should be openly shared with the family, to enable them to contribute their views and to influence the outcome, including being clear about what is

expected of them and why. We must explain what we want to do unless to do so might compromise a child's safety or compromise a criminal enquiry.

Andrew Turnell and Steve Edward's *Signs of Safety* model provides a method of engaging families in understanding what is needed to keep their child safe and to clarify their involvement and the expectations of agencies. At its simplest this can be understood as containing four domains for inquiry:

- What are we worried about? (Past harm, future danger and complicating factors)
- What's working well? (Existing strengths and safety)
- What needs to happen? (Future safety)
- Where are we on a scale of 0 to 10 where 10 means there is enough safety for child protection authorities to close the case and 0 means it is certain that the child will be (re)abused (Judgment)?

What we are worried about, that is our hypotheses and our supporting evidence, must be shared with the family and their views sought about what these mean to them, and what they think professionals would need to see to be confident that the dangers and risks to their children are being managed and reduced. This involves a skilful approach to families, which moves from simply sharing information and telling families what must change, to appreciative enquiry - seeking to understand the family context and perceptions, and asking them, given what professionals are worried about, they think they need to do or can do to reassure professionals about that information and their child's welfare. Practitioners will need to demonstrate their willingness to understand the family perspective whilst maintaining clarity about the actual and possible danger to the child and what actions the department will need to take if this is not resolved. Central to this is the direct work with family members, and with children to understand and challenge family dynamics and behaviour, and transparency about the actions and intentions of professionals. Further guidance is available in the tools section of this framework.

Use of Finkelhor's four preconditions in sexual abuse can be very helpful in educating potentially protective parents in the initial stages of risk assessment and in working with them to protect their children in the longer term.

There will not always be a consistent view within the assessment 'team'. Agreement will need to be reached on what is a 'good enough' level of parenting and protection so that the family can understand what is expected of them, what they will have to do to meet those expectations, and what are likely to be the thresholds for children no longer needing a child protection plan, or in some cases, for legal action.

In cases where these issues have not been discussed and some level of consensus reached, assessment teams can become split and unable to function, assessments can be flawed and decision making impaired. If dissension remains within the group, supervisory input or an early return to a child protection conference will be required. The process of discussing this issue will, in itself be helpful to the group in planning their intervention with the family.

Partnership

Turnell and Edwards state that:

"Constructive relationships between professionals and family members, and between professionals themselves, are the heart and soul of effective child protection practice."
(2010:18)

Similarly, Munro's principles for a child centred system include 'working with families'. This means being clear with them about concerns and risks and, through, for example, motivational interviewing, and 'signs of safety' interview techniques, engaging them wherever possible in identifying and putting into place the measures that will keep their children safe.

These principles of transparency about our needs and risk assessment approach will support a relationship from the outset in which the safety and wellbeing of children is the paramount concern, and where families, and carers, are enabled as far as possible to play an active part in assessing and managing the actual and likely risks to their children.

Assessment team professionals will also need to regularly jointly assess how effectively they are working in partnership, whether they are all working at a similar level, and what is the highest level of partnership they can achieve without jeopardising the welfare of the child.

Equality and Diversity issues

The impact of equality issues needs to be considered throughout the assessment process. Anti-discriminatory practice involves; empathy, allowing children and families to explain their circumstances, addressing imbalance of power, considering the role that the identity of the worker plays in the process, considering issues of strength as well as weakness, checking out beliefs and hypotheses, being trustworthy and honest, attempting to improve

partnership working at all stages of the process, combating power imbalances in the system, ensuring that institutionalised abuse is limited, appropriately using resources and systems to protect and promote children's health and development and understanding the effect of your professional power.

A good assessment will use a diversity model and will address these issues- see **Practice Guidance for safeguarding children in minority ethnic culture and faith (often socially excluded) communities, groups and families** published by the pan London Safeguarding Children Boards, 2011.

Step Three: Gather Information (from a variety of sources)

Information for the assessment should be gathered from all adults who are significant to the child (including separated or estranged parents depending on the specifics of the case), plus, of course, from the child. The assessment team will need to be clear about who, when and why they are approaching people. Issues of confidentiality and consent will need to be addressed as per the Child Protection procedures.

There are a range of tools available to assist workers in gathering information, many of which can be used equally well with adults and children, but which will need to be adapted to meet particular needs e.g. the age and understanding of the child, the abilities of parents with learning disabilities. Key to all of these is the role of direct observation of the interaction between family members and the quality of care given to children. The Salford Graded Care scale places huge emphasis on this, and regardless of whether this specific tool is being used, it is crucial that practitioners note their observations and use these as part of their evidence base when forming judgements in the analysis stage of assessment. Clarity about the interpretation of observed action can also form the basis of helpful, if challenging, discussion with parents about what needs to change and why.

For babies and young children or children with severe learning disabilities who have limited or no language skills detailed observation using specialist workers e.g. nursery nurses can provide invaluable information.

Information gathering tools

The use of **genograms** (or family trees) is a particularly helpful way to engage families and to clarify complex relationships, to indicate gaps in knowledge and to make visible intergenerational and life cycle issues. They can be used to gather information and to work therapeutically. As they can be powerful in raising painful and suppressed memories, it is important to explain what a genogram is and what it is likely to raise before undertaking this task. Some of the symbols used can have a considerable but unintentional impact. For example the use of X to symbolise the death of a family member may be very hurtful. Family members should be asked what symbols they would wish to use. Once the process is completed with the family, a neat version should be produced on the child's record.

Eco-maps are also a useful visual tool but should not be seen as a static record of the child or families eco-system. Family relationships change - children may feel hostile towards a

parent one week and have resolved the conflict the following week. Therefore eco-maps should be undertaken on a number of occasions to map the changes. It is preferable, particularly when working with children not to draw eco-maps on paper but to use moveable objects to represent their ecosystem. Play people can be used or cardboard circles on to which can be drawn happy, sad and angry faces. The child can then choose the appropriate play person or face to represent themselves and the people or things they are identifying as significant and be able to move them around to indicate what their feelings are and how they can change. This type of approach is empowering as it gives children and families greater control over the information-giving process, it can provide information that a structured question and answer session would not illicit, and may help families to gain insights and to assess their own situations.

Scales, and questionnaires - To accompany the Assessment Framework, the Department of Health developed a number of models, scales and questionnaires for social workers to use in their work with families, children and adolescents. These can form part of the workers 'tool box' to help assess different aspects of risk, neglect, emotional abuse, resilience and vulnerability, as well as models of change and are available on the intranet.

The use of these tools will assist analysis later in the **stepwise** model.

Step Four: Test and Evaluate

This stage of any assessment, and particularly risk assessment is particularly important, but often given limited attention. Workers frequently use most of the time allotted to the assessment to gather information and produce a report which details this but fails to evaluate the information or draw conclusions. This step requires asking:

"Is my information right?"

Have I missed anything?

Do I understand correctly- or have I misunderstood something?

Have I proven or disproven one or more of my hypotheses about what is happening and am I now in a position to state what is actually evidenced or still of sufficient concern for me to be worried about possible danger or harm to the child?"

Although it is usually only the social worker who evaluates the information gained through a risk assessment, this is not good practice as inconsistencies, different interpretations of evidence gathered and differences of opinion may only come to light as the assessment report is being presented to parents, other professionals, a conference or a court. Following this testing step at this stage will support a more accurate analysis which parents and other professionals are able to understand as they have been engaged in proving or disproving the hypotheses about danger or risk of harm and know what the areas of disagreement and consensus are likely to be.

Each hypothesis should be tested against the evidence gathered and the findings of the assessment must be evaluated by the 'team' including the family. The analysis of risk should then be undertaken jointly with them, unless this places the child in greater danger and/or there is immediate risk which needs to be addressed through emergency action, as outlined in the child protection procedures. Emergency action to protect should not however remove the need to follow the step wise process once the child is in a safe place.

Professional supervision will also provide the opportunity for practitioners to reflect on the evidence and its relevance to the initial hypothesis and resulting analysis of risk. At this stage, the practitioner should be using the theoretical models outlined below as a frame of reference, and checking back with others about the validity of their hypotheses and conclusions and the accuracy of the data collected.

Review hypotheses; are new ones emerging. What evidence is there to confirm or disconfirm hypotheses? Are you able to demonstrate in your assessment report the methods you have used to test out the hypotheses and why you have discarded or retained each one?

Step Five: Analysis

Analysis can be defined as a step by step conscious, logically defensible process. There is a deliberation over the different elements in a situation in a systematic and organised way. The strength of an analysis is that it encourages openness about reasoning and so potentially holds any work open to scrutiny.

A robust analysis focusses upon relevant factors, organising decision-making in a way which both improves their quality and makes them professionally defensible. It provides an evaluation which:

- manages the risk
- puts the decisions in a recorded form that enables people later to see how a decision was reached
- informs a continuous process
- enables the reliability of a decision reached to be assessed

The more one can move along the following scale, the higher the reliability:

- informed clinical judgement
- personal experience of the situation, the service user and the child
- sound research which relates to the risk assessment factors involved
- balance of potential losses against potential gains; choices and options available; the element of responsibility, e.g. a parent who continues risky behaviour knows this means a child cannot be left dependent on them and when professionals will move between support and intervention (to balance their care and control responsibilities).

What are the weaknesses in the situation being analysed? - What are the factors in the situation being analysed that make the occurrence or continuance of abuse more likely? What are the weaknesses or vulnerabilities in the arrangements for the care or protection of the child? There may be weaknesses in the services available to the family or their willingness to cooperate with agencies or services?

Awareness of probable sources of error – which may come from the person being assessed (e.g., poor reliability as an informant), the assessor (a difficulty in suspending personal values), or the context (such as an agency bias in favour of one or other party involved).

Checking whether all necessary information has been gathered – as in some cases, few sources of data may be needed to develop a strong understanding of the behaviour whereas in others we may need to qualify any predictions made due to the entirely inadequate or irrelevant material.

Identify when specialists or other outsiders need to be involved – predictive accuracy is often improved when we utilise the combined skills across agencies and sometimes beyond. Where this is lacking, workers should explicitly state how their recommendations have been affected by such omissions.

What are the strengths in the situation being analysed? – A wide view should be taken of possible strengths including extended family and community supports but they should be related to the abuse or neglect under consideration. A supportive extended family will be a strength where parents need to share some of their burden of child care they may be of little use in protecting a child from a sex abuser. Consideration should be given to factors from the carer's past where there is evidence that these are strengthening current coping capacity. For example a parent who has coped for a number of years prior to the current concerns shows the capacity under other circumstances to provide good enough care for the children.

What is the level of risk? What is the likelihood of the abuse occurring or recurring? – determining the level of risk is a complex decision-making process where the worker considers the following conditions or criteria:

- Number of risk factors (how pervasive are they?)
- Severity of risk factors (how severe?)
- Duration of risk factors (how long have they been present?)
- Parent or child's ability to control risk factors
- Family strengths and resources
- Ability of worker or agency to provide necessary services

What are the factors which reduce/mitigate risks? -an admission by a parent of the problem to and a willingness to cooperate with the treatment and intervention programme could be considered as reducing risk. The use of interventions known to bring benefits e.g. appropriate, regular medication or intervention for mental illness would also reduce risk.

It is difficult to always know which questions to ask although the following predictive questions might be of assistance:

- Parenting skills and the capacity to learn- can methods of teaching and imparting parenting skills, matched to the parent's method of learning, be improved?
- Health care and safety – can education improve understanding and a timely response to needs?
- Decision-making - can education or intervention impact upon thoughtful/mindful decisions and reduce frequency of poor quality decisions?
- Parent and child interaction – emotionally is often as warm, attached and committed as for most parents. Multiple deprivations can reinforce tendency to a more restricted punitive response. Research indications are that this may be due to not knowing what standards to set, what behaviours to reinforce and non-punitive ways to ignore or reprimand undesirable behaviour. The danger of filling the gaps with middle class family norms and patterns as goals also has to be avoided.
- The capacity to generalise learning to adapt it to new situations.

What does research tell us about the presenting scenario? - social workers and managers should always reflect the latest research on the impact of neglect and abuse when analysing the level of need and risk faced by the child.

What are the prospects for change in the situation and for growth? – is there evidence of growth and positive change in the circumstances that have surrounded the abuse or given rise to concern? Or is there evidence of deterioration and negative change in the situation? A risk assessment should attempt to forecast how a situation will develop in the future and clearly the capacity for improvement or deterioration in the current conditions is central to any such assessment.

What can be offered to build on any strengths and combat weaknesses? – at all stages in the process it is important to see help and support as running alongside the assessment, so even at an early stage it would be important to

comment on availability of help and likelihood of it being used. There is much research evidence that the majority of child protection investigations are triggered by poor or inadequate parenting rather than deliberate acts of abuse or neglect. Offering support services will be an outcome of many assessments. A positive response from parents to such services is helpful but we need to be aware of their not cooperating together with the danger of superficial cooperation hiding deeper resistance.

What is the risk associated with intervention? – We need to consider whether the benefits of intervention outweigh the problems of separation if, for example, if we are considering removal.

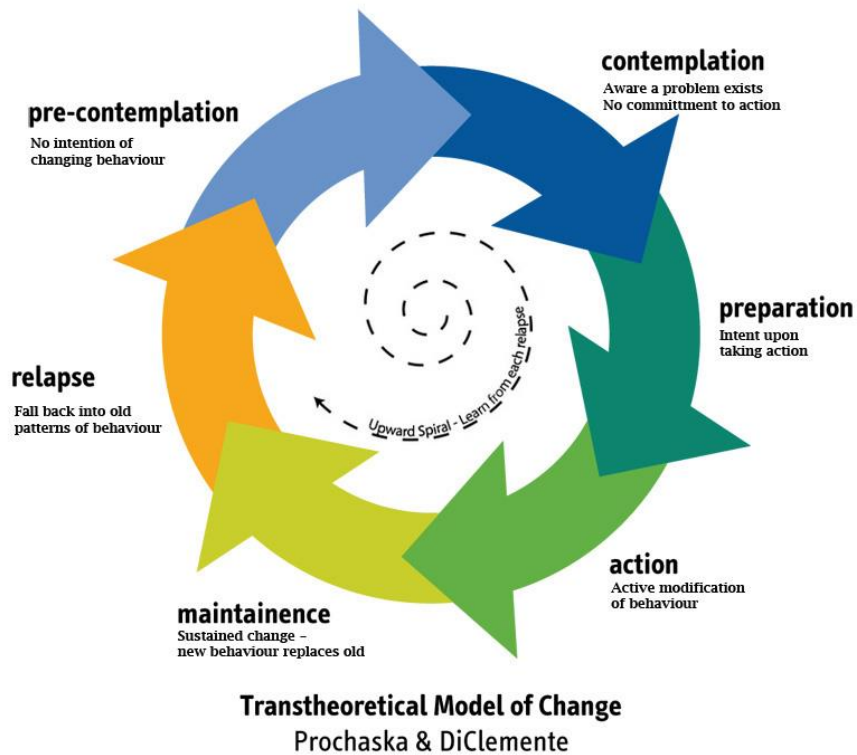
What is the family's motivation and capacity for change?

An assessment of **capacity to change** adds a time dimension and asks whether parents – over a specified period of time and if provided with the right support – are ready, willing and able to make the necessary changes to ensure their child's well-being and safety. The main aim of an assessment of parental capacity to change is to reduce uncertainty.

Although we know a lot about the factors which impact on parenting capacity, assessing parents' capacity and motivation to change long-established patterns that have a negative impact on the safety and welfare of their child is a difficult, but important, task.

Capacity to change requires that parents:

- **recognise the need to change** (parents' attitude to the abuse or concerns)
- **willing to engage** in the change process (acknowledgement of the difficulties and a preparedness to work towards change)
- have **the ability to make changes** – for example, to learn new parenting skills or engage social support
- **invest effort** into the change process and
- **sustain initial effort** over time.



However, care needs to be taken not to discriminate against parents solely on the basis of their taking a different view of the abuse from the social worker or other professionals. Cooperation also needs to be viewed in the context of the seriousness of the abuse or neglect. Some incidents are so serious that compulsory protective action may need to be taken despite evidence of cooperation of parents.

Grey Areas

Grey areas may include other known potential risk factors which have not yet impacted the child; areas where further information needs to be gathered and assessed including any questions for which the response was 'don't know'; and lines of further enquiry which may resolve significant divergence of views among professionals.

Views of the Child(ren) and Family of Presenting Risks

The voice of the child is central in any assessment and future plans.

The child's views should be recorded accurately and using their own words wherever possible. Ascertaining the views of parents and other significant people will demonstrate their capacity and motivation to change.

It will also highlight any minimisation or denial of presenting risks.

What is the contingency plan? – Good practice indicates that a contingency plan should be in place, akin to concurrent planning.

Risk analysis

Risk analysis can be defined as '*establishing the likelihood that a particular event will occur*'. Much of the work is therefore necessarily the collection of information which will enable the professional to make a predictive judgement about risk in particular families. However, the most difficult aspect of this process has always been the analysis of the information collected - What weight are we to ascribe to particular factors?

In risk analysis, whilst the risks and vulnerability model referenced above provides a useful basis for assessment, the Resilience and Vulnerability Matrix is a helpful tool for putting this into action.

Step Six: Decide Plan

All assessments should lead clearly into a plan which stems from the identified risks and strengths in the family, and should start from the overall goal, that is the prevention of a poor outcome if the child's needs are not met, or in the case of risk assessment, the protection of the child from the identified danger, for example, sexual abuse by X.

It should then list each risk and need, and the action required, by whom and when, to address that risk. This will take the form of key objectives and tasks which must be **SMARTER**

Specific

Measurable

Achievable

Realistic

Time bound

Evaluate

Review

The principles set out in the previous steps must also be applied, in that the plan must be clearly communicated to all involved and families must be supported to understand what exactly is expected of them, why, and by when. It should also be clear what level and type of support will be offered to enable them to meet the objectives of the plan, plus what the consequences will be if tasks are not undertaken and objectives are not met.

The Plan will usually be agreed at a formal meeting, either at a child protection conference, a child in need planning meeting, or a core group, and must be owned by all involved.

Child protection chairs will expect to see a completed assessment using the **stepwise** framework, and underpinned by the relevant analysis tools for the type of abuse or harm identified as an issue for the child. Where there is more than one danger or type of abuse, the conference should make a decision about what the greatest priority is in terms of risk to the child - this can be identified through use of the Brearley assessment model, which can then be supported by other tools such as Finkelhor.

Step Seven: Review

All assessments which lead to a plan for a child will be subject to regular review to ensure that they are making a positive difference to the child and to the level of risk posed to them. Whilst this will usually happen as part of the child protection, children in need or children looked after reviewing process, it is imperative that plans are also reviewed in supervision in the light of any change in the child or adults' circumstances and the impact of this on the identified risk factors and strengths.

Supervision should be proactively used to monitor the progress of risk management plans and to re-evaluate the risk analysis in the light of new information, including, for example, changes in social worker or failure to access or achieve a service which is part of the protective plan.

Risk analysis is a dynamic process and must be continuously reviewed against the framework and models provided here.

Risk Assessment Tools

Risk and Resilience Matrix

The Risk and Resilience Matrix is an evidence-based tool which supports and informs the assessment of risk. It is not designed or intended to be used as a standalone assessment tool or process. Its purpose is to provide a structured framework to consolidate existing / on-going assessments and present the 'lived experience' of the child and changes over time in the visual which is the Risk and Resilience Matrix.

The Tool is informed by a number of evidence-based models and practice frameworks including the work of Daniel and Wassell and their 'Risk and Resilience' model and underpinning research; the work of Turnell and Edwards 'Signs of Safety'; the 'Strengthening Families' models of practice; Research in Practice & Dartington publication 'Analysis and Critical Thinking In Assessment' and the 5 'Anchor Principles'; the core principles for child protection practice as set out in the 'Munro Review of Child Protection: Final Report' (2011) Resilience has been viewed as "normal development under difficult conditions" (Fonagay et al, 1994). Focusing on the positives and the strengths in a child's life is likely to help improve outcomes by building the protective network around the child and the self-protective potentials within the child. (Daniel B & Wassel S, 2002). At the same time, it is important to be alert to factors of adversity or vulnerability, which may potentially impact upon the child's well-being and the interaction of these factors with any identified resilience and protective aspects. The resilience/vulnerability matrix can be used as a tool to support practitioners explore the key concepts of **adversity/protective factors** and **vulnerability/resilience**.

Promoting resilience, assessing vulnerability

The purpose of risk assessment in social work is closely associated with the prevention of existing or future significant harm and this involves weighing up both the positive and negative factors in children's circumstances. An understanding of 'resilience' is important when analysing information in terms of providing an evidence based framework within which to consider judgements about risks and protective factors within children's lives. There are commonly agreed factors which are shown to promote resilience in children:

- The child has a secure relationship with one reliable adult
- Influence of another stable adult figure or figures
- Positive social support networks and a social role

- Positive school experiences
- A sense that one's own efforts can make a difference
- Personal or 'inherent' qualities
- A child's own coping skills
- A child's view of themselves
- Plans for the future
- Early and compensatory experiences

Familial and parenting characteristics that enhance resilience:

- A confiding relationship with a partner or with others
- Cohesive and consistent parental relationship
- Parental self esteem
- Role models
- Adequate finances and employment opportunities
- Constructive coping styles and deliberate parental actions to minimise adversity for children
- Openness and good communication
- Knowledge of 'protective factors'

Community factors that enhance resilience:

- Cultural connectedness, values and identity
- Access to health, education, welfare and other services

(Dalzell and Sawyer, 2011)

Using this in the assessment process alongside consideration of risk factors for children should lead to more inclusive and imaginative recommendations that explore how positives can be strengthened and deficits reduced (Dalzell and Sawyer, 2011).

Protective factors for children

Babies

- The input of specialist medical practitioners when babies are born with the HIV or Hepatitis B or C virus.
- Attendance at clinic for immunisations and developmental reviews.

- The presence of an alternative or supplementary caring adult who can respond to the developmental needs of the baby.
- Wider family support and good community facilities.
- Sufficient income support and good physical standards in the home.
- The relevant parent acknowledges the difficulties and is able to access and accept treatment.
- Regular supportive help from primary health care team and social services, including consistent day care.
- An alternative, safe and supportive residence for mothers subject to violence and the threat of violence.

Protective factors for toddlers

- The presence of an alternative or supplementary caring adult who can respond to the child's developmental needs and provide continuity of care.
- Wider family support and good community facilities.
- Sufficient income support and good physical standards in the home.
- The relevant parent acknowledges the difficulties and is able to access and accept treatment.
- Regular supportive help from primary health care team and social services.
- Regular attendance at nursery or similar day care facility.
- An alternative, safe and supportive residence for mothers subject to violence and the threat of violence.

Protective factors for primary school age children

- The presence of an alternative, consistent caring adult who can respond to the cognitive and emotional needs of the child.
- Sufficient income support and good physical standards in the home.
- Regular attendance at pre-school facilities.
- Regular, long-term support for the family from primary health care team, adult social services and children's social care, and community based services.
- Long-term package of services to meet the diverse and enduring, complex and multiple needs of some families.
- The relevant parent acknowledges the difficulties and is able to access and accept treatment.
- An alternative, safe and supportive residence for mothers subject to violence and the threat of violence.

- Children have the cognitive ability to rationalise drug and alcohol problems in terms of illness. This enables them to accept and cope with parents' behaviour more easily.

Protective factors for adolescents

- The presence of an alternative, consistent caring adult who can respond to the cognitive and emotional needs of children.
- Sufficient income support and good physical standards in the home.
- Regular supportive help from a primary health care team and social services and community based resources, including respite care and accommodation.
- Regular attendance at school.
- Positive school climate and sympathetic, empathic and vigilant teachers.
- Attendance at school medicals.
- An alternative, safe and supportive residence for mothers subject to violence and the threat of violence.
- Peer acceptance and friendship.
- A supportive older sibling.
- Social networks outside the family, especially with a sympathetic adult of the same sex.
- Belonging to organised, out of school activities, including homework clubs.
- Being taught different ways of coping and being sufficiently confident to know what to do when parents are incapacitated.
- An ability to separate, either psychologically or physically from the stressful situation.
- Sufficient income support and good physical standards in the home.
- Practical and domestic help.
- Regular medical and dental checks including school medicals.
- Factual information about puberty, sex and contraception.
- Regular attendance at school.
- Sympathetic, empathic and vigilant teachers.
- Belonging to organised, out of school activities, including homework clubs.
- A mentor or trusted adult with whom the child is able to discuss sensitive issues.
- An adult who assumes the role of champion and is committed to the child and '*acts vigorously, persistently and painstakingly on their behalf*' (Department of Health 1996, p.24).
- A mutual friend.
- The acquisition of a range of coping strategies and being sufficiently confident to know what to do when parents are incapacitated.
- An ability to separate, either psychologically or physically from the stressful situation.

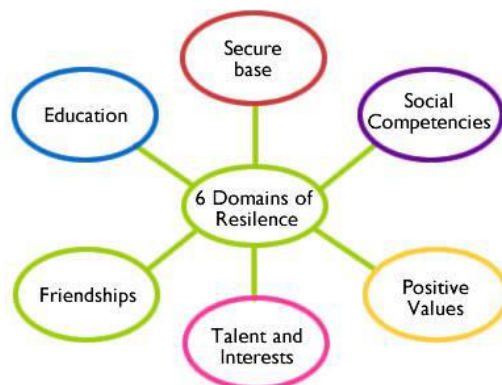
Some common factors for child vulnerability are:

- Age – children from birth to six are always vulnerable
- Physical disability – regardless of age, children who are unable to remove themselves from danger and are highly dependent on others are more vulnerable
- Mental disability – children who are cognitively limited are vulnerable in a number of areas; recognising danger, knowing who can be trusted, meeting their basic needs and seeking protection
- Perceptions of provocative behaviour – a child’s emotional, mental health, behavioural problem can be such that they irritate and provoke others to act out toward them or to totally avoid them
- Powerless – regardless of age, intellect and physical capacity, children who are highly dependent and susceptible to others are vulnerable. These children typically are so influenced by emotional and psychological attachment that they are subject to the whims of those who have power over them
- Defenceless – regardless of age, a child who is unable to defend him/herself against aggression is vulnerable. This can include children who are oblivious to danger. Remember that self-protection involves accurate reality perception particularly related to dangerous people or situations
- Children who are frail or lack mobility are more defenceless
- Non-assertive – regardless of age, a child who is so passive or withdrawn to not make his or her basic needs known is vulnerable. A child who cannot or will not seek help and protection from others is vulnerable
- Illness – regardless of age, some children have continuing or acute medical problems and needs that make them vulnerable.
- Child vulnerability is the first conclusion you make when completing a risk assessment
- A judgement about child vulnerability is based on the capacity for self-protection
- Self-protection refers to being able to demonstrate behaviour that
 1. Results in defending oneself against threats of safety and
 2. Results in successfully meeting one’s own basic (safety) needs

The three fundamental building blocks of resilience that underpin the many factors are:

1. A secure base, whereby a child feels a sense of belonging and security
2. Good self-esteem, that is, an internal sense of worth and competence
3. A sense of self-efficacy, that is, a sense of mastery and control, along with an accurate understanding of personal strengths and limitations.

Gilligan goes on to identify six domains that contribute to the three building blocks of resilience. These 6 domains can be used understand the areas of impact on a children’s resilience:



(Gilligan, 1997)

Each of these domains can be assessed using the My World Triangle as demonstrated below:

Child Health and Development	Six domains of resilience
Health	Secure base
Education	Education
Emotional and behavioural developments	secure base/friendships/positive values
Family and peer relationships	Secure base/friendships
Self-care and competence	Secure base/social competencies

By relating the resilience model back to the assessment framework it enables the practitioner to integrate resilience into their assessment and planning work.

- Understanding a child’s resilience factors are crucial when planning to intervene effectively.
- Plans need to take into account both the external protective factors and the internal resilience. These should then be understood in the context of the adversity and protective factors within the child’s family, friends, community and environment.

This can focus practitioners from moving from assessment to intervention aimed directly at influencing such factors, this can help to reduce additional harm and promote positive change. Utilising support from extended family members through restorative practices such as family group conferences and strengthening community resources can improve outcomes for children and young people.

This model can be enriched by adding the understandings of the cultural context that have been drawn from the work of the International resilience project. By placing the child within their cultural frame and understanding resilience as the ability to negotiate the tensions between the individual and the environment around them it helps broaden the focus from the ages and stages and attachment based model that applies more accurately to experiences of western children (Brigid Daniel & Sally Wassell – Assessing & Promoting Resilience in Vulnerable Children).

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Ten questions to explore when thinking about a child's resilience and vulnerabilities.

These questions could be adapted for use with other agencies and families.

1. Why are you worried?
2. What sort of behaviour is causing the problem?
3. Who is being affected, how, when and where?
4. When did it start?
5. What factors are present in the child's background (e.g. divorce/illness?)
6. What are the present and past risk and protective factors?
7. Which risk factors be decreased?
8. Which protective factors can be increased?
9. What are the strengths in the child, family, community, school, and how can they be built on?
10. What is the worst thing that could happen?

Decide which factors and responses to minimise and which to maximise will support planning for the child.

Factors you identify to maximise or to build on are likely to be the protective and resilience factors, which will ultimately lead the child to full and capable life as an adult.

Factors you decide to minimise or reduce are likely to be those which would lead to increased vulnerability and adversity in adult hood.

By placing the child at the centre of the risk and resilience matrix and working from their individual characteristics and experiences, you can ensure a tighter focus. Adult needs are less likely to drive the planning if the focus remains on the child's experience, their understanding of that experience and the corresponding child actions and interactions.

Tools to support understanding the child's world

- The Assessment Framework
- Bear cards or any other type of picture cards that are about feelings
- Resilience handbooks by Sally Wassell and Bridget Daniels, *Assessing and Promoting Resilience in Vulnerable children I, United Kingdom, Jessica Kingsley Publishers, 2002*
- Risk and resilience matrix, found in *The Child's World, Assessing children in need*, Edited Jan Howarth, United Kingdom, Jessica Kingsley,
- Strengths and difficulties questionnaire from Scales and Questionnaires.
- A people house – where a child demonstrates their attachment by placing people/animals in different rooms or parts of a house. Who they leave out is as important as who they put in.
- Observing how children respond to other people – at school, in small peer group, one on one, to managing disappointment, to attempting to learn something, to how they sit, stand and move in 'strange situations' Use story telling – it helps with children if you can keep the story outside the child – it lessens the blame and guilt feelings that children often have when they do not understand what adults want.
- Sand play – let the children build a world and then tell you about it in a structured session
- Photos – let them take photos of things that matter to them, take photos of what they make in sessions. Ask if you can use them to help people understand what they see as important.
- Check with other adults what you have observed including parents, family members, and nursery or school teachers, other children (when appropriate).
- Check in with the child about what are thinking to see if they see it the same way. Make sure you pick a measurement that a child can relate too and check in how they are feeling about things each session – such as colours that THEY give a feeling too (black is sad, red is angry, yellow is happy), or beads that they can weigh or objects to stack if they cannot count properly (the heavier this is the bigger problem it is for me – the lighter the easier it is for me)

Factors should be mapped across the *Risk and Vulnerability Matrix* below:

1. Identify the factors that create and evidence resilience in the child, and those that indicate a protective environment.
2. Identify the factors that create vulnerability in the child and their circumstances.
3. Identify the factors that are creating adversity at this point in time.
4. Ascribe each of these a value between 1 and 5, with 5 being strong and 1 being weak.
5. Plot where you assess the child to be on the matrix according to these values - that is which quadrant do you assess the child as being in?

Is this a hypothesis or do you have enough information to evidence this? How will you now test it out and ensure that you develop a safety plan that moves the child towards *Quadrant 1*?

Clearly children who are assessed as being predominantly in *Quadrant 4* are the most vulnerable and will need a safety plan in place to increase protective factors and promote resilience.

The resilience matrix analysis forms the basis for discussion with the child, family and other practitioners on what should go into the child's plan. This will include what actions need to take place to improve protective factors and resilience, what needs to happen to reduce adversity and vulnerability and who is going to carry out those actions. Reviewing a child's progress will be an essential part of a child's plan. In some circumstances, especially complex cases, it will be useful to revisit the resilience matrix in reviewing the child's progress.

Putting a numerical value to your assumptions and plotting a pictorial diagram is a good way to clarify and test out thinking across professionals and with children themselves. (Adapted from Daniel and Wassell (2002) *Assessing and Promoting Resilience in Vulnerable Children* (Workbooks 1, 2 & 3, *The Early Years, The School Years and Adolescence*), London: Jessica Kingsley Publishing).

Some key questions to consider include:

- Are the protective factors outweighed by the adversity factors?

- List the factor(s) which are most significant for the child and describe the likely impact on their well-being if they remain unmet? (address each separately)
- Specify what needs to change to strengthen resilience and their protective environment
- What is the capacity of the family to achieve this change?
- What does the child/young person and the family want to happen|?
- What would indicate that progress is being made?
- Is there any other information you need?

The simplest approach to initial risk assessment is to reference the factors that create resilience or undermine it for children, and to map these along the risk and vulnerability matrix. Some of these are set out previously and are replicated below, however the risk factors for sexual abuse and exploitation should also be considered:

Child

Source of Vulnerability	Source of Resilience
Young age	Higher IQ
Disability	Good attachment
Earlier history of abuse	Good self esteem

Parent or Carer

Sources of vulnerability	Sources of resilience
Domestic violence	Social support
Serious substance misuse	Positive parental childhood
Chronic serious psychiatric illness	Good parental health

Severe learning disability	Good relationship with sibling
History of victimisation – abused as a child	Education
	Work role

Family and environment

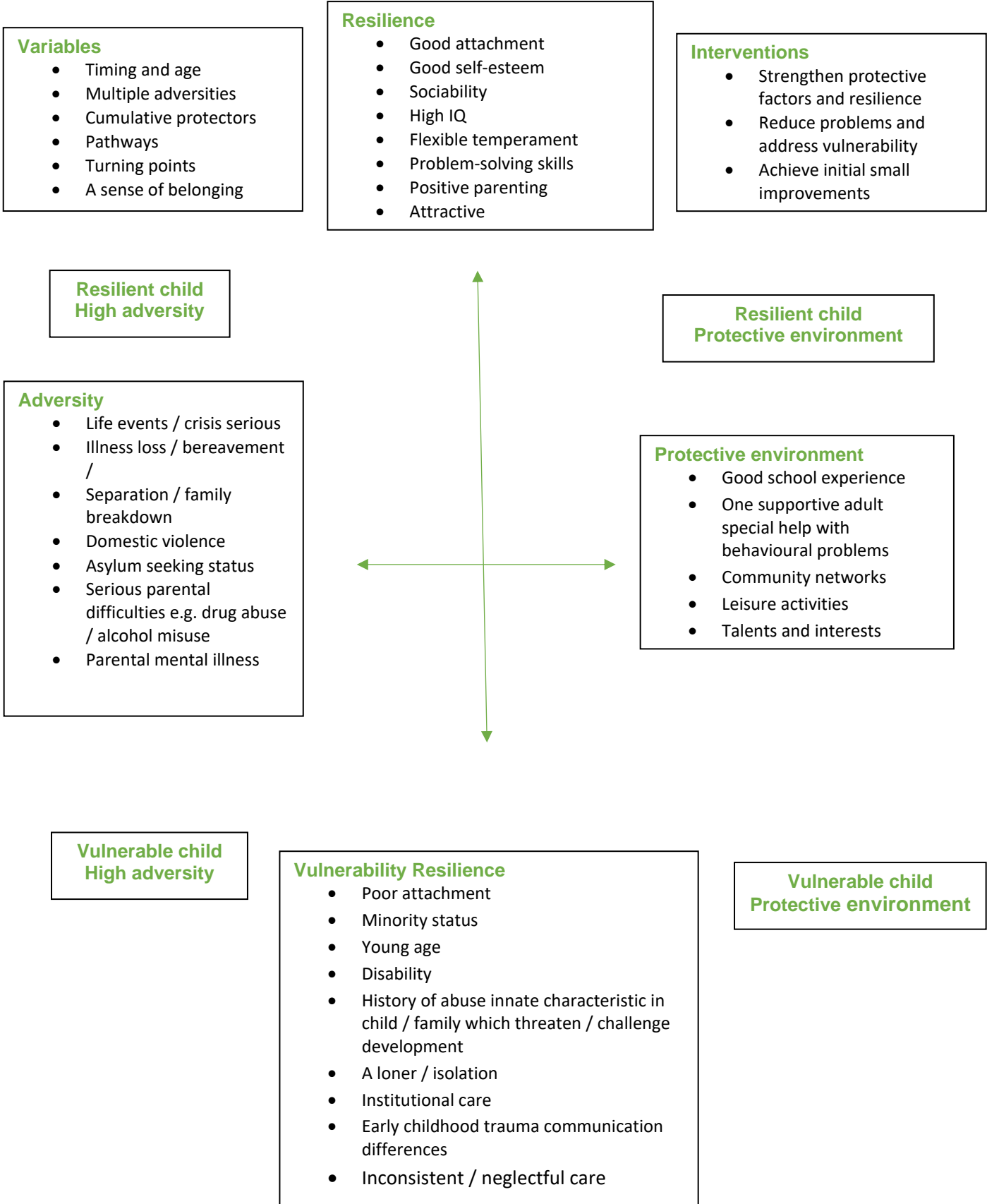
Sources of vulnerability	Sources of resilience
Run-down neighbourhood	Committed adult
Poor relationship with school	Good school experience
Weak fabric of social support	Strong community
Poverty	Good services/supports
Social isolation	
Inter-generational cycle of abuse	

1. Identify the factors that create and evidence resilience in the child, and those that indicate a protective environment.
2. Identify the factors that create vulnerability in the child and their circumstances.
3. Identify the factors that are creating adversity at this point in time.
4. Ascribe each of these a value between 1 and 5, with 5 being strong and 1 being weak.
5. Plot where you assess the child to be on the matrix according to these values - that is which quadrant do you assess the child as being in?

6. Is this a hypothesis or do you have enough information to evidence this? How will you now test it out and ensure that you develop a safety plan that moves the child towards *Quadrant 1*?

Resilience / Vulnerability Matrix

(Calder, M 2006)



You can use the matrix with family members and with your assessment colleagues, including in supervision, to map out how safe you consider that children are at any point in time, as well as to test out your hypothesis about how strong some 'protective' factors really are. Putting a numerical value to your assumptions and plotting a pictorial diagram is a good way to clarify and test out thinking across professionals and with children themselves. (Adapted from Daniel and Wassell (2002) *Assessing and Promoting Resilience in Vulnerable Children* (Workbooks 1, 2 & 3, *The Early Years, The School Years and Adolescence*), London: Jessica Kingsley Publishing).

Paul Brearley: Hazards, Dangers and Protective Factors

This model is based upon a set of questions developed by Paul Brearley and used initially in risk assessments carried out by the NSPCC. By considering the possible danger and then dividing the hazards - the things that might cause the danger to occur - into two types, workers and the family are helped to examine the processes which may lead to a child being harmed, and to consider how this might be avoided. It is consistent with the approach taken by the Assessment Framework as it focuses upon both adverse and protective factors in the family and community networks that might heighten or reduce the danger to the child. It also encourages professionals to identify gaps in information and their implications for child safety.

The following steps should be taken:

1. Summarise the information which you have collected in relation to the factors present in each area being assessed, i.e. child's developmental needs, parenting capacity, family and environmental factors.

2. List the dangers - what are we worried about in relation to the danger of harm to the child? This should be specific, for example, that y will be/is being neglected by mum/dad, y has few friends and is becoming isolated and introverted, is vulnerable to strangers and may be sexually exploited, engaged in criminal activity etc. *The danger is something you want to avoid, so what possible events would you fear in these circumstances?* Consider not only the significance of these dangers, but the chances of them occurring.

3. List the hazards in the case and divide them into two - *a hazard is something which might result in the danger being realised, or which increases its likelihood - something which brings about the danger you want to avoid - refer to the adverse factors in the Assessment Framework.*

Hazards should be divided into those which are predisposing, or **static**, and those which are situational, or **dynamic**.

- predisposing hazard - *something which creates vulnerability and therefore makes the danger more likely. It may need to be activated by something else, such as a situational hazard*
- situational hazard - *this is something which happens, and which has an immediate effect directly related to the danger*

Predisposing hazards (static factors) are the sort of risks which are factual, and usually fixed at the time of the assessment, for example, the child is under 5 years old and has special needs, or a child has been sexually abused (and is therefore vulnerable to further abuse).

Situational hazards (dynamic factors) are more dynamic, and concern events or developments in the case, such as parents stop co-operating, or the protective parent decides to re-unite with the child's abuser, or a parent loses their job and faces debts and stress as a result

The latter are factors which are more likely to be amenable to change, and should be the key focus of the child protection plan. They may also indicate the greatest level of risk. The more hazards identified the greater the level of risk.

4. List the strengths - list what you consider to be the strengths in the case - those **protective factors** whose effects counteract the danger and make it less likely to become a reality.

5. Balance these out - make a judgement - you need to balance these out, by making direct links between hazards and strengths and their inter-relationship between the three Domains so that you are making a professional judgement about which strengths offset which hazards. What are the remaining hazards? Can these be offset by the provision of services or by further work? In what way, and upon what evidence do you base your judgement? Unresolved hazards will increase the likelihood of the danger being realised. This will be your risk outcome - is it acceptable? You should also refer to the weighting guide below.

Risk Weighting

This involves listing the identified dangers, hazards, risks and protective factors in the relation to each of the 3 Domains of the *Framework for the Assessment of Children in Need and their Families* then ascribing a weight to each factor as follows:

Risk: On a scale of 1 to 10, how concerning is each risk factor in relation to the danger posed to the child or children? 1 is lowest risk, and 10 is highest. - the danger is, as above, the feared outcome for the child, which needs to be clearly stated in language that everyone understands.

Protective Factors: On a scale of 1 to 10, how positive is this in protecting the child from the identified danger, and/or meeting their needs? Why do you think this? How has it been tested?

Compare the totals: Where there is a significant difference between a) and b), the situation is one of high risk, and you now need to consider what the expected impact of intervention will be in lowering the total.

Repeat the process including different support services as possible protective factors, and determine whether this lowers the total sufficiently for the core group to agree that the risk is acceptable. You should include in this exercise what the optimum level of service should be, and then repeat it to reflect what is actually available *and used by the family?* How significant is any mis-match?

Obviously the weight ascribed to each factor will be crucial to determining the final outcome, and this can only be a matter of professional judgement based upon our knowledge of research into child abuse and the long term impact of adversity on children.

Research suggests that adverse factors, or risks, within the Domain of Parenting Capacity tend to have a more significant impact than those in other Domains, and that these should therefore be more highly weighted than other factors.

Research is also clear that the greater the number of adverse factors present, the higher the likelihood of poor long term outcomes for children. The advantage of this model is therefore that it reflects the presence of a high number of adverse factors with a high overall score, and therefore will provide a clear indication that intervention is needed to safeguard and promote the child's welfare.

Supervisory guidance should be used to ensure that decisions arising from an assessment are shared, agreed and lead to an appropriate level of service provision and intervention, with clear measurable objectives related to the outcomes sought for the child.

Neglect and Emotional Abuse

The Salford Graded Care Profile may be used for all situations where actual or likely neglect is the key risk identified in the information gathered to date. It is also helpful in emotional abuse in focusing discussion on the behaviours that demonstrate this so that professionals can be specific about what it is that needs to change. It is designed to be completed with the family, over several sessions, and can be adapted to suit the individual family circumstances and to engage them in discussion and debate about what is reasonable for children to experience. Young people can also be asked to complete it and a comparison made between their perceptions and those of their parents or professionals.

(Guidance on using the Graded Care Profile and the Graded Care Profile form is available on the Islands Safeguarding Children's Partnership website)

Child Sexual Exploitation

CSE is a form of sexual abuse and can have a serious impact on every aspect of the life of the child. CSE is broader than formal 'prostitution' - the spectrum of situations include seemingly 'consensual' relationships where sex is exchanged for attention, accommodation, food, drugs or gifts or involves serious organised crime and child trafficking

Any child or young person may be at risk of CSE regardless of their family background or circumstances. There are strong links between children at risk of CSE and behaviours such as absconding, bullying, substance misuse and self-harm and those with low self-esteem and poor self-image. Some children are particularly vulnerable such as disabled children; children looked after, care leavers, migrant children and unaccompanied asylum seeking children.

Children are at risk of CSE from both people they do and do not know. Due to the nature of grooming methods used by perpetrators, it is common for the child or young person not to recognise that they are being abused. CSE can be organised or involve one perpetrator acting alone

Perpetrators target children and young people where they may be without adult supervision e.g. shopping centres, or social media.

When carrying out an assessment where it is considered that child may be at risk of Child Sexual Exploitation the risk indicators and factors below should be considered.

Risk indicators	Factors to consider
Education	Truancing. Regular non-school attendance. Excluded, behaviour problems
Missing / running away	Comes in late, Stays out overnight without permission, Persistently reported as missing from home or care. Missing for short periods of time on a regular basis.
Sexualised risk taking	Inappropriate dress/ change in physical appearance. Meeting unknown adults / Getting into unknown cars Internet used to meet adults. Older partner (+ 5 years)

Rewards	Unaccounted for money, expensive items such as new mobile phone, jewellery.
Contact with risky adults / environments	Associating with other known sexually exploited children and / or unknown adults. Extensive use of mobile phone. Accessing unknown premises (homes) or known risky areas. Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites.
Coercion / control	Reported limited /reduced contact with friends, family or in placement. Disclosure of physical /sexual assault (later withdrawn) Physical injuries. Child's whereabouts is unknown/ estranged from family.
Sexual health	Reported STI(s), Miscarriage(s), Termination(s)
Substance use	Level of drug and alcohol use/ different. Increased/ Concerning/ Chronic.
Emotional health	Low self-esteem, self-harm, eating disorder. Attempted suicide, Violent behaviour, angry outbursts, offending

Other factors include:

Child: Witnessing/experiencing domestic violence, family conflict, Child 'Looked After', Homeless / sofa surfing, Learning disabilities, Financially unsupported, Migrant/refugee/asylum seeker; Sex with a child less than 13 years / with a disabled child
Family; Abuse and/ or neglect in family; Parental Substance misuse; Death, loss or illness of a significant person in the child's life; Adult prostitution; Parental Mental Health, Parental Learning Difficulty or Disability

Risk identification

The CSE Risk Identification Tool should be completed to aid identification of the level of risk to the child or young person

The Information Report should be completed and forwarded to the CSE and Missing Coordinator

Vulnerability and Risk should form an essential part of the child's plan.

Child has additional needs due to disability or a complex health condition

The following pointers are for you to think of the additional information that is needed due to the child's disability and / or health needs

Disability

Be clear here but try not to jargonise or take it straight from a medical dictionary.

Does the child have a diagnosis?

People reading this need to know how the condition or impairment affects the child or young person so make sure you put next to each diagnosis how this manifests and how it limits or affects the young person, how it makes them feel and how the equipment they have to use impacts on them emotionally and socially.

If they have a health issue how the treatment plan will impact upon their life and do they understand their condition?

Think about the child's health history – have they met their developmental milestones if their disability / health has / will impact upon this.

Communication Needs

In the section about the child's preferred method of communication do not take it as read what school or the parents say. Often young people have reported that they will communicate in a certain way as that's all they are given and when asked what they would prefer to use they come up with other methods including behavioural and gesture methods.

All these need noting and please do not forget behaviour is a form of communication and should not be ignored. Often children and young people are labelled wrongly as having no communication when they do but it is neither verbal nor following a recognised pattern – but your work with the child or young person will give you a clearer insight into this.

If the young person or their family or carers will need an interpreter make sure you state this here and be clear about what dialect or method they use.

Do not assume if the young person is hearing impaired and from a different cultural community that BSL will be their preferred method of communicating.

If the young person uses a pathfinder or talk box to help them communicate – make sure you see when the best time is for visiting to ensure they have access to this device.

If the child or young person is on medication check whether there are times when they are unable to engage due to the effect this may have either just before or just after taking it.

Understanding

This relates to things such as the following:

- how the young person understands what is asked of them
- how they appear to be able to listen to people when they talk to them
- what their understanding is of the language used around them – you need to take into consideration if they use BSL or Makaton or a talk box device and if this is used at home

Expression

This relates to things such as the following:

- how the child or young person is able to communicate – speech, noises, behaviour, movement, BSL, Makaton
- how confident they are in communicating
- how they structure their speech
- about naming and identifying objects, people and things in their life

Interaction

This relates to things such as the following:

- how they express themselves to others
- how they play with others
- how they are in small and large groups
- what they are like with peer groups in school or nursery
- about social behaviour such as knowing about sex and sexuality and about friendships and keeping safe

This should look at how people involve the child or young person in decision making about the things in his or her life. Also how the young person feels they are included in decision making. They may be asked but do they feel that their views opinions and wishes are heard or even valued.

If they need equipment to communicate or use a method to help them such as Intensive Interaction this needs stating here so that anyone possibly caring for them can see if they

need any training or support to do this to enable the child or young person to feel comfortable and able to communicate to the best of their ability.

From your observations at home and at school (and maybe within respite settings) you will be able to note and reflect on how the child or young person's communication may differ in these settings.

If the parents struggle with communicating with the child or young person then who could help them with this – if they see that they need help?

Reason for Undertaking this Assessment / Presenting Issues

Is this assessment being completed to assess a Child in Need, for a child to access short breaks or due to safeguarding concerns?

Any team working with a disabled child – have universal and targeted services been accessed / notified – if so what services are involved and what services were unable to meet the needs of the child.

Reason for undertaking this assessment – Regional Specialist Team only

Is the child being assessed due to their health condition and subsequent treatment plan?

Child's Profile

Don't just talk to the parents – talk to the child / young person – what do they see are their strengths and weaknesses and how do they feel about undertaking things away from the family home. How are they affected emotionally if they receive respite – do they like it do they look forward to it. How do they feel about going to activities away from home?

Would they like to do more – don't assume anyone has ever asked a disabled child the same questions as one without health needs or a disability – they may desperately want to go to scouts or brownies but the parent or carer may not be aware you can get help to enable them to do this !

If you are observing the child in home and at school or at a placement make sure you state this and reflect on what is said and what you observe. Do they have an understanding of their disability / health needs and how do they feel about themselves?

Family History

This should look at how the parent/s care givers are trying to work to help the child or young person feel valued and loved within the family home or care setting.

How do the family work as a unit to support the child or young person through change or challenging situations which may affect the whole family?

Environmental Factors

If the child or young person is at an age where they want more independence or they need more privacy – how will this be accommodated within their current home or care settings?

What sort of help does the young person want in relation to getting independence?

If the child has a shared care arrangement – are there adaptations and equipment available in all care giving settings which safely and appropriately meet the needs of the child or the young person and the people providing care for them?

If the young person has medication or incontinence pads or equipment – where is this stored?

Is it safe in relation to other young people or children within the home?

Things to consider in relation to safe care within an environment which need noting here are:

- Does the child or young person wander at night and if so how safe are they?
- How independent is the young person within the home or care setting?
- Do they turn taps on?
- Do they try to get out of the house? If so how are they kept safe is an alarm needed on doors and windows to alert care givers within the home or care setting to this?
- Does the young person have access to the kitchen area and is this safe?
- Is there a ramp to the entrance and exit to the property which is safe for the young person and anyone moving them to use?
- If there are stairs in the property is the child or young person safe to use them?
- If the child or young person is in a wheelchair are they able to get through the doorways?
- If the child or young person is in a wheelchair are they able to be safely taken up and downstairs?
- Is the child or young person able to use the toilet safely? Is there a toilet for them downstairs or do they have to be lifted upstairs if they need to toilet or do they have a commode?
- How does the child or young person wash or bathe – do they have a special bath or adapted bathroom – if not how are they bathed and is this safe for the person helping them?
- If the child or young person has oxygen how is this transported within the home?

If the child or young person needs lifting – is there tracking and a hoist which is safe and suitable for his or her needs?

If the family have financial concerns ensure that they are signposted appropriately for benefits advice. Can charitable support be accessed to offer support?

This section should include any issues about how the family and the child or young person are able to access facilities and sports and leisure activities within their community. Would they like to do more – don't assume anyone has ever asked a disabled child the same questions as one without health needs or a disability – they may desperately want to go to scouts or brownies but the parent or carer may not be aware you can get help to enable them to do this.

Are there any resources within the area that the child or young person can access and are the family or care givers able to support them in doing this or would they benefit from someone independent to do this?

What amenities like doctor, dentist shops etc. are available within the neighbourhood? Does the family have to travel to get to these and is this a problem for them in taking the child or the young person if he or she has equipment such as a wheelchair or medical equipment to take with them?

If the young person has a condition such as an Autistic Spectrum Condition are they able to cope with the noise and business of social and leisure activities and events? If not how could they be helped to access these more happily or comfortably?

What does the young person want to do in relation to social and leisure activities?

How do they feel emotionally about what they can and cannot access in relation to social and leisure activities?

Are they currently attending activities which are either way below or way above their capacity or understanding? If so what could you find in the Short Breaks Guidance and Directory or on the Intranet which may be more suitable and how could the child or young person get the most suitable and appropriate help to enable them to access this and build better and safe social relationships?

Social Worker's Analysis

In this section there needs to be a clear analysis on what additional needs the child has due to their disability or health condition.

What part of these needs are the parents able to meet and how?

What do you analyse is unmet need and the risk it raises to the child?

Play

This section should look at issues such as the following:

- if the young person is able to engage in group play
- if the young person plays more with older or younger children/young people

If the young person engages in more solitary play

- can the child/young person engage in turn taking activities
- can the child/young person differentiate between fantasy play and reality
- can the child/young person cope with changes in their play environment
- if the young person has obsessions about certain activities
- whether the young person is able to initiate play
- if the young person does not like a specific sort of play such as messy play or play involving textures

Stimulation

This section should look at issues such as the following:

- this should show what the child or the young person chooses to engage in for stimulation such as games preferred activities preferred

Leisure

This section should look at issues such as the following:

- how the young person deals with social and leisure activities whether they can cope with noisy environments
- what their behaviour is like when they are in busy social situations
- what activities or groups they may like to attend or do attend

What is the risk to the child's lifespan and / or safety due to their disability or health condition? Is there any risk associated with treatment?

Is an additional assessment required e.g. under the continuing care criteria, O.T. assessment?

Family Strengths and Protective Factors

This part of the assessment you will need to look at not only if the parents or carers are able to care safely for the child or young person but if they have the equipment they need to do this within their home/s.

Has a parent / carer assessment been offered and what was the outcome?

Talk to the parent/s or carer/s about how it feels to care for the child or young person and the parent carer assessment may inform more information about this and you may be able to

reflect back to them what you feel are their strengths which can be very valuable if a parent or carer is at the stage of feeling very frustrated or exasperated due to their caring responsibilities or what they feel could be a significant lack of support.

Consider from whom the child accesses / receives emotional support.

Parents

- This should report on what you have observed during your visits to the child/young person during your visits to the home or care setting.
- What are the levels of attachment like between the mother and the child or young person?
- Describe the relationship mother and child/young person have been observed to have.

What are the levels of attachment like between a father/step father or partner if there is one within the household?

- Describe the relationship father/step father or partner and child/young person have been observed to have.
- If there is shared care arrangements how does the child or young person relate to the other adult care givers within the other care setting?
- Is there a clear difference between the roles of the parents/adult caregivers within the home?
- How do the parent/s/adult care givers react to any challenging behaviour from the child/young person?
- How do the parents meet the differing needs of their children especially if a single parent?
- How do the parents support each other / work together in relation to the child's disability / health condition?

Siblings

Here you should comment on what you have observed during your visits to the home or care setting in relation to siblings or step siblings.

- How does the child/young person interact with their siblings/step siblings?
- What is their opinion of them?
- How do the siblings/step siblings react to the child/young person?
- What is their opinion of their brother or sister?
- Is the child/young person able to respect the privacy of their siblings/step siblings

- If the child or young person has much younger siblings should they ever be left alone with them – what is their awareness of safety?

Wider Family, Other Care Givers Friends and Peers

Here you should comment on what you have observed during your visits to the home or care setting in relation to their wider family, peer groups and any friends they have including things like:

- Do they see their grandparents? (if so do they see maternal and paternal and if so how often and how do they react to this)
- What is the child or young person's view of their grandparents? – seek the views of the child/young person and their family/care givers.
- Do they see their wider family? If so where and when and what is their opinion of this and how do they behave – seek the views of the child/young person and their family/care givers.
- Does the child/young person have friends?
- Do they go to see friends or do they stay at home most of the time
- What is the young person's view of who is their friend
- How does the young person react to people of the same age? Do they prefer the company or to play with older or younger people – what have you observed during your visits to home and school.

Analysis and Professional Judgement

Don't forget to look at the non-material things – what would the young person like to do if they had the support – how do the things in their life make them feel and if they are not happy – how could they get some help and support from a trained health professional to resolve this?

Is the need in the home, out of the home, in relation to care, independence or leisure activities?

- Does the child's needs meet the criteria for Short Break provision?
- Does the analysis of need concur with the reasons for undertaking this assessment?

Recommendations including outline plan

Does your recommendation include further assessment support from other agencies?

- Continuing Care
- Learning Disability Nurses
- CAMHS
- Occupational Therapy
- Referral to charitable sources.

Domestic Violence

1. Are you concerned that there is domestic violence in a family you are working with?

- Common indicators include physical injuries; anxiety and distress; frequent appointments and missed appointments; reluctance to go home; mental ill health; alcohol and substance misuse, self-harm and attempted suicide. The woman may appear vague, frightened, anxious, depressed and/or distressed.
- Is there a history? Check any available records. A victim may have been to your agency previously and presented with some of the common indicators mentioned above. Many women experience repeat incidents of violence and harassment before disclosing to anyone. The frequency and severity of DV incidents often increases over time. Check if tagged as MARAC case.
- Common indicators for children include: anxiety and distress, sudden changes in behaviour, withdrawing, acting aggressively, difficulty separating, and increase in stress related illnesses, bedwetting, school absences etc.

2. How to approach the issue

- See the victim alone and in private.
- Ask direct questions sensitively. This forms part of routine enquiry so all women are asked.
- If she is accompanied, do not insist on seeing her alone. Arrange an alternative, safer opportunity.
- Be honest about why you are asking.
- Explain your confidentiality procedures.
- Use a registered interpreter if required.
- If violence is denied record that she has been asked and her response.
- Explain that you may ask her again at future meetings.

3. Routine Questions

Research shows that women are more willing to disclose their experience of domestic violence if they are specifically asked about it. It is therefore important to ask about domestic abuse in a direct but non-threatening and sensitive manner. For example:

“Many women experience violence and abuse from their partners so we ask all women about this. Can you tell me about your relationship, do you ever feel frightened by your partner?”

Women should be told about why the questions are asked i.e. because of the extent of domestic violence, the need to monitor it to ensure women receive adequate services, to enable staff to refer women to appropriate agencies and provide her with useful information.

4. What if domestic violence is disclosed?

- Emphasise confidentiality.
- Be clear about any limits to confidentiality.
- Be clear about the boundaries of your role.
- Ensure availability of information about agencies and other support she can access.
- Sign post and/or refer appropriately with her consent.
- Explore with the woman her understanding of the impact on her children.

5. Children

- *Recognise* the links between abuse of women and abuse of children.
- Ask if children are aware of, have witnessed, been involved in the violence.
- Wherever possible, provide child friendly play areas/supervision and interview the woman separately.
- Never use children as interpreters.
- Talk to the children about domestic violence where appropriate.

6. Safety/Risk assessment

- Assess with the woman the current risk to herself, children or any vulnerable adults in the household.
- If applicable, use your agency's risk assessment tool.
- Identify a place of safety if she is in immediate danger.
- If there is no immediate danger, discuss short term and long term safety planning.
- If appropriate undertake a DASH risk assessment and refer to MARAC.

7. Information and support

- Offer the woman support by listening to her and believing her.
- Do not be judgemental.
- Emphasise that she is not to blame for the violence.
- Place the responsibility for the violence with the abuser.
- Offer opportunities for on-going support.
- Provide information about specialist support, local agencies.
- Offer support to access these agencies.
- Respect her decisions if she does not want further help, is not ready to leave or address the situation, but make it clear she can come back another time.

- Share information proportionately with partner agencies, including referral to MARACs, and seek her consent to do so.

8. Additional Issues for Women from Vulnerable Groups

Be aware of a victim's personal circumstances and any additional needs they may have as well as the additional barriers to support them may face, for example:

- Disabled women may face disability discrimination and often feel they are not listened to or believed. They may be dependent on their carer who is also their abuser.
- BME women may experience racism, honour based violence, be concerned about immigration issues or have no recourse to public funds.

This is not an exhaustive list but provides some prompts on the additional issues that need consideration. It is essential not to stereotype but to treat each woman as an individual and listen to her specific issues and respond accordingly by providing relevant information or referring to specialist services.

9. Action Planning

- Assess the impact of the domestic violence on the children.
- Identify with her any action she will take.
- Identify any action you will take on her behalf.
- Make arrangements for future support or follow-up meetings.
- Make referrals with her consent.
- Indicate any information which will be shared with colleagues to ensure consistent support.
- Explain why you have to check my bedrooms. Or anything else you check.

Assessment and intervention with domestically abusive men

Six key factors that are significant in understanding domestic abuse and can form a framework for your assessment:

1. Childhood attachments

Research suggests that a majority of court mandated interpersonally violent (IPV) perpetrators, and a significant minority of IPV perpetrators found in general populations, have a disorder of their personality, with the prominent disorders being borderline personality disorder (BP) and anti-social personality disorder (ASPD).

Research also suggests there are a sub-group of batterers who were insecurely attached to their partner, likely to experience depression, and have BP personality traits (i.e. an intense fear of being abandoned). They will go to great lengths to prevent this, with extreme reactions within relationships, including impulsivity and extreme displays of emotions. Alcohol can play a part within this.

This sub-group are also likely to have a criminal record for non-violent offences and substance use problems. Those men who score highest on BP traits also used the most physical aggression and controlling and emotionally abusive behaviours. The cause of this behaviour is usually related to early experiences of childhood abuse, separations, losses and disruptions which lead to poor adult emotional regulation and a fragile sense of self.

There is also a connection between Anti-Social Personality Disorder (ASPD) and Borderline Personality Disorder (BPD), substance use and domestic abuse. Many people with ASPD and BPD misuse substances

2. Anger Management

There has been a lot of discussion in the area of domestic abuse around the role of anger in explaining why some men are violent and abusive. It has been thought that men's abusive behaviour is generally premeditated and this is certainly the case for some men to varying degrees. For other men however, their violence in particular is not premeditated and they need to learn anger management techniques to keep their partner physically safe.

Men who have anger management problems will typically self-report losing their temper and having verbal and physically violent outbursts in a variety of settings. Most importantly their

violence will not be solely directed towards their partner. These men are also likely to have criminal convictions for reactive violence.

It should be noted at the same time that men who have anger management issues may also have difficulties with premeditated, controlling behaviour. Typically, the controlling behaviour does not include physical violence but will be expressed through bullying and intimidation, in an attempt to stop their partner doing something, or alternatively make their partner do something. Where there is pre-meditated use of violence in a relationship a weapon may have been used and there may also be evidence of stalking or persistent harassment.

Pre-meditated violence and controlling behaviour is likely to be linked to the perpetrators damaged attachment style.

3. Culture, Religion and IPV

Culture and religious views are complicated and varied. They are not homogenous and vary according to where we live and who we associate with. There is evidence that cross-culturally women's empowerment is related to their victimisation and the perpetration of violence and abuse. Historically a patriarchal culture predominated within western society although this is now much less the case. We need to be clear therefore in our assessments exactly how cultural and religious beliefs have impacted on the perpetrator.

We need to assess whether the perpetrators beliefs about women, relationships and the use of violence have an impact on his behaviour towards his partner. As with substance use and IPV we need to decide whether culture (whether it be on a micro or macro level) and religious beliefs are:

- Unrelated to IPV: In this scenario the man does not have oppressive or concerning beliefs about women, relationships or violence.
- Used to rationalise IPV use: In this scenario there is not a connection between his beliefs and abusive behaviour but he uses cultural justifications for his abuse. These justifications mask deeper issues in his life.
- A direct cause of IPV: Beliefs about women, relationships and violence are deeply engrained in the perpetrators thinking and will be evident through the way he talks about these issues in everyday life.
- An additive effect: There are other significant factors behind his abusive behaviours but his beliefs about women, relationships and violence contribute to his abusive behaviour.

How do we work with abusive men (Assessment and Intervention?)

Reassure, get the man's story. Listening to someone's story is not colluding! You need to hear this story so that you can contextualise their behaviour. Think of a time when you have been seeing a doctor and they have not listened to your explanation of symptoms. They may (or may not) come up with the right diagnosis but we do not feel respected!

You don't need to challenge everything he says. (Even if you don't agree!) Occasionally emphasise, this is his perspective without being judgemental. 'So, from your perspective...'
This enables him to tell his story without him thinking you agree with him!

Encourage the person to consider his partners perspective, 'how would your partner describe the incident'? Listen to whether they can actually do this, this is an important indicator for the readiness and ability to change.

Treat an honest account with as much suspicion as a minimising, denying and blaming account! M,D,B is good, it shows discomfort with the behaviour, honesty is only good if it is accompanied by discomfort.

It doesn't really matter if they deny the index assault as long as they admit elements of abusive behaviour. The more time has elapsed since the behaviour, the more likely we are to admit it, it's quite normal! If he says he hit her 3 weeks ago but not last night, work with what he is giving you. Whilst his denial really disrespects his partners experience, by working with where he is at you can reduce the risk for the future, which is probably what his partner wants the most.

Agree they should not expect their partner to be interested in the discussion. If you do some work with a man they will often say that they are going to go home and discuss the work with their partner. Their motives for this could be very mixed. Warn them against this, it may cause an argument and it is quite likely she is not interested. Similarly, if you set homework this should not be done by or with his partner.

Intervention with men in Guernsey

Sarnia Programme run by Probation Service

Caring Dads Programme run through the Kindred Centre

Pre-birth Assessment

1. Introduction

There are a range of circumstances where social workers may undertake pre-birth assessments.

The pre-birth assessment will be completed using the Pre-Birth Assessment form on Mosaic and should be completed within 45 working days (9 working weeks).

2. Planning

Multi-agency planning commences as soon as possible after the pregnancy is confirmed to plan the assessment.

It needs to be established who will undertake the assessment. It is good practice for assessments to be co-worked. Other relevant agencies will contribute to the assessment. The assessment should take place as soon as possible to enable decisions to be made in good time.

The impact of parental difficulties should be informed by professional advice and understanding from relevant agencies such as addiction services, disability services and mental health services etc., who should be involved in the planning of the assessment.

Where English is not the first language, or there are literacy or communication issues this should be taken into account in the planning stage. The use of an interpreter or advocate should be considered. Workers need to be aware of any risks to their own safety during the assessment and these may need to be addressed in supervision.

3. Purpose and Aims of the Assessment

The purpose and aims of the assessment are to undertake a thorough assessment of individual and family functioning and home circumstances. It is to identify the previous and current concerns in a family and the family's perception of these.

A further aim is to identify the strengths and positives within the family. The assessment will assess the potential and ability to maintain changes; identify support networks and identify risk to the child post birth and other children in the family.

The outcome of the assessment will identify the course of action, for example child in need plan, child protection plan or legal action.

4. Safeguarding Plan

It is good practice to draw up a Safeguarding Plan between the Children & Family Community Services and parents. The agreement should outline the reason for the assessment, its purpose and aims, how the assessment will be carried out. This should be agreed at the multi-agency planning meeting at the start of the assessment:

- Areas to be covered in the assessment
- Dates, times, venues of sessions and who will attend each session
- How the assessment will be shared and with whom
- Expectations of those participating in the assessment
- What parents can expect of the Assessor(s)

Parents should be seen alone and as a couple. Extended family members may need to be contacted. Assessment sessions will normally take place at the family home and local area office. One of the sessions in the family home should assess the home environment and preparations made for the baby's arrival.

It should be clearly stated that part of the process will be to liaise with other agencies.

5. Area to be covered

Assessment should follow the guidelines set out for completion of a child and family assessment.

In addition the following areas should also be addressed:

- Individual history of parents, including any offending history;
- Assessment of strengths / safeguards
- Assessment of risks
- Parental understanding of concerns
- Practical arrangements for baby's care
- Capacity for and motivation to change

6. Practicalities in Undertaking the Assessment

The task of completing the work is a joint task and it is recommended co-workers alternate responsibility for leading and recording the sessions. Levels of experience and expertise need to be taken into account when planning who will lead a session.

The sessions should be recorded as fully as possible and typed as soon as possible following the session. Keep all rough notes for future reference as these may be required in Court.

Both co-workers need to meet with the supervisor jointly to discuss progress with the assessment and any developments or difficulties. It is important to review the progress of the assessment mid-way through.

7. Dealing with specific situations

Any difficulties which arise during the course of the assessment should be discussed as soon as possible with your manager. Any early indications of positive change should be clearly recorded, along with an analysis of the impact and meaning of this.

8. Going Forward

The assessment report should make a clear recommendation about identified risk to the expected baby, any protective factors and any service required, that would enable the parent(s) to provide care for the child.

The family plan from the family meetings should be provided to, and considered within that process. If a decision is taken to hold an Initial Child Protection Conference, the report (or the conclusion) may be submitted to the conference.

This conference should take place 6-8 weeks prior to the estimated due date of the child. If a decision is taken not to hold a conference then the Team Manager should convene a meeting to discuss the outcome of the assessment and any future planning, based upon the family meeting plan where available.

It is the responsibility of the allocated workers to ensure the family, the hospital and all other professionals are fully aware of the plan for the child post birth, and it is clearly recorded on Mosaic should the birth happen outside office hours, with unambiguous language.

If removal at birth is planned the Team Manager should convene a planning meeting with appropriate hospital staff and police to plan management of the birth and subsequent removal.

Assessment of a perpetrator of child sexual abuse

The following identifies two key models for understanding and responding to sexual abuse: Finkelhor's four preconditions, and Ward's Pathways. This is followed by mapping the risk factors identified in international research as they apply to sexual abuse and offending in different settings including the factors that increase risk in 'victim' families. Finkelhor provided the seminal work on which the risk assessment tools developed here are based. However, the detailed research into risk characteristics that follow on from his original work are referenced to ensure that there is a broad understanding of the presumptions and evidence that underpin the risk assessment and management approach being recommended. This does not preclude specialist assessment and indeed where relevant this is also referenced, for example in the management of sibling abuse or adolescent sexually worrying behaviour.

An overview of the research relating to Harmful Sexual Behaviour in children and young people is also presented here, and there is then a final summary overview of relevant factors to consider.

Finkelhor's 4 preconditions

David Finkelhor identified four preconditions for sexual offending:

Motivation - Predisposition to offending/ sexual predisposition to children (being sexually aroused by children, sometimes including having an emotional congruence with children which becomes sexually motivated or driven)

Overcome internal inhibitors - distorted thinking (i.e. Overcome conscience or moral taboo, self - persuasion that it is not wrong, children like it, etc. Use of alcohol to lower own inhibitions?)

Overcome external inhibitors - create opportunity (groom or manipulate the environment to disempower any protective adult and ensure one does not get caught; consciously or unconsciously put oneself in a position where there are vulnerable children and an opportunity for 'temptation')

Overcome resistance - undermining or overcoming the child's resistance to the sexual abuse (groom and manipulate the child - threats, persuasion, trickery, use of alcohol or drugs)

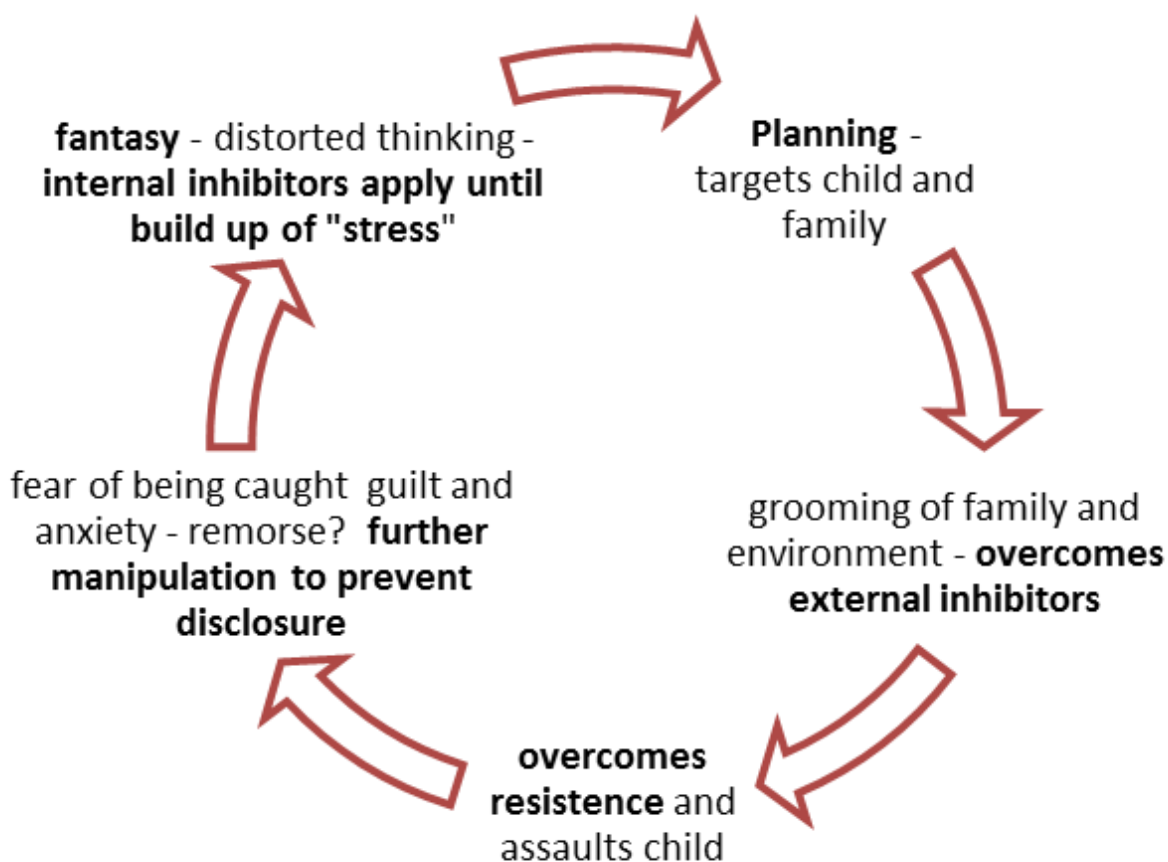
Finkelhor's model has been greatly developed through the work of the NSPCC, Barnardo's, and the Lucy Faithfull foundation and it provides a helpful and evidence based framework for understanding the experience of the child and the potentially protective parents and network, and therefore a means of evaluating and managing risk.

Some assumptions that can be made

Child sexual offenders are not a homogenous group. They will cover a spectrum of behaviour and preferences from those who will only offend once, in certain circumstances, against one child, to those who prefer boys, or girls or prepubescent children of either sex, to those who believe that children have a right to sex with adults and have no preference for age or gender. Others believe that they are showing the child 'love'. Whatever the nature of offence, there will be certain similarities which can assist both in identifying the level of risk and in understanding the child's experience, and that of the non-abusing parent:

- The alleged abuser holds a position of power in the family and family network
- All offences are premeditated.
- The role of fantasy and masturbation is central.
- The offender will try to deny all/some of the offence by denial, e.g., justification, distortion, minimisation.
- They will seek to lay the responsibility for the offence elsewhere- usually on the child or the non-abusing parent.
- They will say that the offence is '*out of character*'.
- They will have built up a compulsive cycle of behaviour.
- The offender will say '*I won't do it again*'.
- There is no "cure", only control.

The offender's behaviour will follow the following pattern:



The cycle is characterised by denial, excusing and justifying of behaviour, and the alleged or actual abuser will have followed this cycle and may have done so over a period of years. For prolific offenders, the cycle will be completed in a matter of hours and there may be minimal guilt following the assault on the child. The important factor for initial assessment of risk is to consider the first stages of the cycle in terms of the level of planning and manipulation carried out by the alleged offender to gain access to the child. This will give some insight into the experience of the child and the protective adults, as they will have been manipulated to gain their trust and to isolate the child from someone who might protect them, or who will believe them when the abuse is discovered or disclosed.

The child themselves may well also believe that the abuse was their fault, and for many young people, that no abuse has actually occurred but that they have been engaged in a relationship based on 'love'. The abuser will have created in the child fear of consequences, shame, confusion, or loyalty as a result of the 'special attention' which has surrounded the abuse. The

child may well mourn the loss of this aspect of the relationship, which has taken the place of a healthy loving parental relationship.

Finkelhor also suggests the following categories to help professionals understand the impact of child sexual abuse:

- traumatic sexualisation,
- stigmatisation ,
- betrayal and powerlessness.

Each category includes the process by which the perpetrator sets up the abuse, as well as its impact on the child or young person, and the impact will relate to many factors, including the relationship with the abuser, the length of time, the severity of abuse and the degree of emotional manipulation and betrayal. Every child is different, and every assessment must recognise this and seek to understand the child's experience of the offender cycle.

In assessing risk, the practitioner must also consider:

What is the role of the non-abusing parent, if there is one?

Are they complicit, or are they potentially protective?

Research and experience tells us that, in the majority of cases, the mother is unlikely to have known, or if they have suspected are unlikely to have been able to cope with the implications this involves. Their initial reaction is therefore most likely to be one of denial and research suggests a reaction which is akin to bereavement - shock, denial, anger, confusion, depression, and acceptance. The non-abusing parent has usually been targeted and groomed - how did they meet? How has the perpetrator undermined the relationship between the mother and her child so that external inhibitors have been overcome?

However, it is also possible that the woman is complicit, or indeed is the main perpetrator, and this hypothesis needs to be considered at the initial stages and either discounted or evidenced to the extent that it is at least, a continuing possibility. Research suggests that women abuse for different reasons than men, and assessment and intervention will require a different emphasis in the longer term. However in the short term the process is the same - to avert the danger of further abuse for the child and to identify safe caring adults who will help the child to recover whilst longer term plans are put in place.

Where there is a non-abusing parent, the key focus of assessment and intervention needs to be on rebuilding the relationship between this adult and the child if the family are to heal and recover.

This grooming may have extended to wider family and friendship networks, and also to community and work environments. Potentially protective adults may not therefore believe the child and, as above will experience very powerful emotions associated with bereavement.

An alleged offence in a family, must give cause to questions about the alleged perpetrator's interaction with and access to other children.

These assumptions should form the basis of risk assessment and planning aimed at protecting children in future and repairing the damage to familial relationships in order for the child to be believed and accepted and for therapeutic recovery work to begin.

The risk assessment should consider static and dynamic factors (see earlier comment re these terms), that is, predisposing and situational factors as outlined in the Brearley model.

Offenders

The Structured Assessment of Risk and Needs used by the National Offender Management Service identifies four main domains of dynamic risk factors for the abuser:

- Sexual interest
- Social and emotional functioning
- Distorted attitudes
- Self-management

These are the areas on which risk assessment must focus, but they must be evaluated in the context of the situation and environment in which the perpetrator and the victim/child are living and operating. Understanding this can provide a clear guide to what the potential dangers are to a child, and what possible controls can be put in place to safeguard them. As above, it must always be remembered that offender will probably have manipulated the environment to provide opportunity and remove resistance, and this may have been deliberate or on a 'subconscious' level' which has enabled distorted thinking to predominate.

The table below summarises the risk factors identified through Finkelhor, as already described, and also through Ward's Pathways model, which builds further upon Finkelhor's approach.

Finkelhor's 4 preconditions model:

	Preconditions/individual factors	Social/cultural factors
Motivation to sexually abuse	<ul style="list-style-type: none"> • Arrested emotional development • Need to feel powerful and controlling • Re-enactment of childhood trauma to undo hurt • Biological abnormality • Fear of adult women • Traumatic sexual experience with adult • Inadequate social skills • Marital problems 	<ul style="list-style-type: none"> • Masculine requirement to be dominant and powerful in sexual relationships • Erotic portrayal of children in advertising • Male tendency to sexualise all emotional needs • Repressive norms about masturbation and extramarital sex
Overcoming internal inhibitors	<ul style="list-style-type: none"> • Alcohol • Psychosis • Impulse disorder • Senility • Failure of incest inhibition mechanism in family dynamics 	<ul style="list-style-type: none"> • Social toleration of sexual interest in children • Weak criminal sanctions against offenders • Ideology of patriarchal prerogatives for fathers • Social tolerance of deviance committed while intoxicated • Child pornography • Male inability to identify with needs of children

		Preconditions/individual factors	Social/cultural factors
Overcoming external inhibitors		<ul style="list-style-type: none"> • Mother is absent or ill • Mother is not close to or protective of child • Mother is dominated or abused by father • Social isolation of family • Unusual opportunities to be alone with child • Lack of supervision of the child • Unusual sleeping or rooming conditions 	<ul style="list-style-type: none"> • Lack of social supports for mothers • Barriers to women's equality • Erosion of social networks • Ideology of family sanctity
Overcoming the resistance of the child		<ul style="list-style-type: none"> • Child is emotionally insecure or deprived • Child lacks knowledge about sexual abuse • Situation of unusual trust between child and offender • Coercion 	<ul style="list-style-type: none"> • No availability of sex education for children • Social powerlessness of children

Source: Finkelhor, D. (1984, pp. 56-57)

Ward's Pathway Model

The work of Ward and Siegert (2002) is regarded among researchers as being very instructive for investigating the individual's role in committing child sexual abuse. Their theory is often referred to as Ward's Pathways Model. It is differentiated by its explanation of how offenders

use apparently normalised interactions to gain both trust and access to victims. The Pathways Model is a psychological theory that suggests that certain pathways are the key to child sexual abuse perpetration. These pathways stem from "clusters" of problems that are found in the psychology of adults who sexually offend against children. These clusters are:

- Difficulties in identifying and controlling emotional states;
- Social isolation, loneliness and dissatisfaction;
- Offence-supportive cognitions (e.g., belief that everyone sexually abuses children and that children enjoy the abuse); and
- Deviant sexual fantasies.

There can be more than one cluster apparent in any one individual. Clusters are different from the pathways in that they are clinical phenomena that are found among child sexual abusers, whereas the pathways are associated with different psychological and behavioural profiles (Ward, Polaschek, & Beech, 2006).

There can be overlap between the various pathways. The five aetiological pathways that were identified are discussed below.

Ward's Pathway Model

Pathways and developmental trajectories in Ward's Pathways Model

Pathway	Developmental trajectory
Multiple Dysfunctional Mechanisms	<ul style="list-style-type: none"> • Distorted sexual scripts • Idealised relationships • Dysfunctional ideas about children's sexuality • Deviant sexual arousal • Heightened self-esteem based on perceived legitimacy of actions
Deviant Sexual Scripts and Relationship Schema	<ul style="list-style-type: none"> • Distorted sexual scripts plus dysfunctional relationship schema • Sex/intimacy confusion • Vulnerability in seeking sexual activity

	<ul style="list-style-type: none"> • Relationships perceived in sexual terms • Relationships are unsatisfying, Short-term and with periods of rejection
Intimacy Deficits	<ul style="list-style-type: none"> • Normal sexual scripts • Insecure attachments, which lead to problem adult relationships • Maladaptive strategies to avoid unsuccessful adult relationships • Intimacy deficits and feelings of loneliness • Substitutes child as a surrogate
Emotional Dysregulation	<ul style="list-style-type: none"> • Normal sexual scripts • Emotional regulation problems • Unidentified emotional structures • Early established link between sex and emotional wellbeing • Sex used as soothing strategy • Unable to mobilise social supports when stressed • High anger and emotional dysregulation • Child used to satisfy sexual need and punish partner
Antisocial Cognition	<ul style="list-style-type: none"> • Normal sexual scripts • Possesses pro-criminal attitudes and beliefs • General antisocial tendencies • Patriarchal attitude and sense of own superiority • Disregard of social norms re: children and sex • Exploits opportunities to self-gratify
<p>Notes: * Sexual scripts are "the cognitive representations individuals acquire during the course of their development that specify how to behave in sexual encounters" (Ward et al., 2006, p. 64). Source: Adapted from Ward et al. (2006).</p>	

The Pathways Model makes it clear that it aims to explain adult perpetrators' behaviour, not problem sexual behaviours or sexually abusive behaviours that may be exhibited by children who sexually abuse other children. Ward and Siegert (2002) argued that the Multiple Dysfunctional Mechanisms pathway is exhibited by "pure" paedophiles; that is, those who can be diagnosed with paedophilia. Perpetrators with the Deviant Sexual Scripts and Relationships Schema are those who may have a possible history of child sexual abuse themselves.

As Ward et al. (2006) noted, "**In the pathways model situational triggers are hypothesised to interact with the various predispositions of individuals to sexually abuse children. The nature of the situational triggers will vary according to the particular profile of causes underlying each individual's offence trajectory or pathway**" (p. 73) This is closely aligned to the assumptions that are outlined in the Finkelhor model above, that is, that in assessing and managing risk we must make some assumptions until we are able to understand the particular pathology and distorted thinking pattern of the alleged abuser, and the likely stressors that will trigger this thinking and enable him to manipulate the situation in order to gain access to and abuse children.

As above it is important to understand that not all abusers are the same, and that not all abusers will re-offend. However without treatment and control, there is a very high likelihood that they will do so. Risk management and prevention must therefore make the assumption of risk and focus on creating an environment around them and the children in their orbit that will identify and react to any indication that risk is increasing and that the abuser has opportunity to isolate and abuse a child.

Mapping risk factors

Research results on perpetration risk factors

This section presents the risk factors for child sexual offending across the identified relationships and contexts. Before doing so, it is useful to consider what factors have been associated with child sexual abuse overall. These differ from those identified for child abuse (maltreatment) more generally:

Risk factors associated with child abuse and maltreatment (Centre for Disease Control and Prevention, 2014)

Individual risk factors:

- parents' lack of understanding of children's needs, child development and parenting skills;
- parents' history of child maltreatment in family of origin;
- substance abuse and/or mental health issues, including depression in the family;
- parental characteristics, such as young age, low education, single parenthood, large number of dependent children, and low income;
- non-biological, transient caregivers in the home (e.g., mother's male partner);
- parental thoughts and emotions that tend to support or justify maltreatment behaviours.

Family risk factors:

- social isolation;
- family disorganisation, dissolution, and violence, including intimate partner violence; and
- parenting stress, poor parent-child relationships, and negative interactions.

Community risk factors:

- community violence;
- concentrated neighbourhood disadvantage (e.g., high poverty and residential instability, high unemployment rates, and high density of alcohol outlets), and poor social connections.

While there is a crossover with these child maltreatment risk factors, the literature on adult perpetrators of child sexual abuse also emphasises factors such as:

- their history of violence and delinquency;
- their maladaptive sexual behaviours, such as deviant sexual fantasies;
- social deficits, such as lack of empathy and social skills deficits; and
- attitudinal and cognitive variables, such as their attitudes towards rape, the "sexual precociousness of children" and cognitive rationalisations

Indeed, in their meta-analysis of 89 studies of sex offender risk factors, Whitaker and colleagues (2008) found that child sex offenders were more likely than non-offenders to have poorer family functioning, more harsh discipline, poor attachment and generally worse functioning in their family of origin.

Child sex offenders also demonstrated:

- poorer social connectedness to others (e.g., loneliness, poor social skills);
- significantly higher sexual externalising problems;
- higher sex drive and preoccupation with sex;
- more deviant sexual interests;
- greater sexualised coping;
- attitudes that are more tolerant of adult-child sex; and
- cognition that minimises perpetrator culpability.

On most of these measures, there were no significant differences between child and adult sex offenders. Whitaker et al. (2008) concluded that *while child sex offenders are different from non-offenders, they are not different from adult sex offenders*. In other words, while both child and adult sex offenders share a number of risk factors with general (non-sexual) offenders, the point of difference relates to the sexual component of their behaviour. This is echoed in other research on the attitudes of child sex offenders, which finds that their beliefs and attitudes in relation to children as sexual objects; general preoccupation with sex; and beliefs about entitlement, authority or control distinguish them from a range of other offenders.

Perpetrator risk factors

Personal characteristics

- *Biologically unrelated male*: A well-documented risk factor for certain forms of child sexual abuse is the presence of a biologically unrelated male. In authority, care and extra-familial relationships this can mean a male who has unrestricted access to a child due to their authority status (e.g., a teacher or priest) or by being considered trustworthy by the family (e.g., a neighbour). Within a familial relationship, the male can be an uncle, step-father, de facto or boyfriend to the mother who is biologically unrelated to the child. This risk factor has been calculated from victim response surveys and other records where the offender's relationship to the victim is detailed. In cases of online perpetration, research indicates that males unknown to the victim are the main offenders.
- *Young*: Generally means the perpetrator is under the age of 25 years, although for peer and sibling abuse it means under 18 years.
- *Psychological deficits*: The perpetrator has a low IQ or is cognitively impaired.
- *Traditional gender values*: Generally understood to be values that place women and children in an inferior position to the male offender's wants and needs. It can mean also acting on these held values; for example, through preventing a female partner from controlling her own finances, expecting children to be deferential to the offender's authority within the family, etc.

- *Interest in child exploitation material:* The offender has accessed and used such material.
- *Computer savvy:* The perpetrator is a very competent user of information technologies. They can upload material, connect with other users, encrypt uploads and downloads, can possibly access a "dark-net" (anonymous online file sharing service), and find ways of evading detection on the Internet.
- *Substance misuse:* When perpetrators currently or at the time of the child sexual abuse have alcohol or other substance abuse issues.

Social characteristics

- *Highly sexualised environment:* A highly sexualised environment for adult perpetrators is usually defined as one where there is high pornography consumption and a high degree of sexual discourse between adults, and where the children are often exposed to this behaviour. It does not necessarily mean creating or accessing child exploitation material. For peer and sibling offenders it often means they have witnessed sexual acts between adults in their home, or have been exposed to high levels of pornography. It has been measured from self-reports, or from online offenders, generally from details taken about their search and browsing histories prior to their arrest.
- *Social isolation:* The offender has not had close or significant friendships and relationships in their childhood or early adulthood.
- *Low socio-economic status:* The perpetrator may be unemployed, or have low-level employment.
- *Low education:* When the perpetrator has education only up to high school graduation level.

Childhood history and past behaviours

- *Child sexual abuse history:* If the perpetrator was a victim of child sexual abuse when a child, they are more likely to become a child sexual abuse perpetrator themselves.
- *Childhood neglect:* This is usually defined as the perpetrator having experienced neglect as a child or adolescent rather than referring to someone who neglects their own children. There are not always substantiated or reported cases of neglect in the

history of the perpetrator, so this is often measured by self-reports describing childhoods that have been characterised by neglect.

- *Childhood physical abuse:* The offender was physically abused as a child.
- *Large family size:* The perpetrator grew up in a family with three or more children.
- *Early parenthood:* The perpetrator was aged 15 to 20 years when their child was born.
- *Prior sexual criminal behaviour:* The perpetrator has a history of sexual crime, not necessarily against children.
- *Prior non-sexual criminal behaviour:* Criminal behaviour of a non-sexual nature either while an adolescent or adult.
- *Violent behaviour:* The perpetrator has a history of violent and abusive behaviour. This is usually defined as other, non-sexual, criminal behaviour (for adults or adolescents) or problems with regulating emotional outbursts in children. For adults and adolescents it has been measured by looking at criminal records, reports from child protection services or self-reporting from the perpetrator.

Victim risk factors

- *Poor family cohesion:* This is usually defined as a family where one parent may be absent due to personal/health issues (e.g., depression or substance abuse), where parents may be emotionally or physically absent and the child is being raised by other family members, or where there is poor health in the family. It is often linked with low-income families. Where there is poor family cohesion an offender may have more opportunities to sexually abuse children, or in the case of female, Indigenous and peer/sibling offenders, they may themselves have a history of poor family cohesion that has led to behavioural and developmental issues.
- *Domestic violence in the family:* Child sexual abuse is often found in families where there are other forms of violence and abuse being perpetrated against the children or the perpetrator's partner. Familial and some Indigenous offenders of sexual abuse may also be committing domestic violence. Peer/sibling sexual abuse perpetrators may have witnessed domestic violence in the family; likewise female offenders. It is measured through self-reports or reports from the police or child support authorities, or the offender may have been first reported for domestic violence and it is through this that their sexually abusive behaviours are discovered.

Risk factors for adult familial offenders

The following risk factors for familial offenders have been identified by the research:

- biologically unrelated male (including step-father, de facto boyfriend of mother)
- traditional gender values
- highly sexualised environment
- social isolation
- prior non-sexual criminal behaviour
- poor family cohesion and
- domestic violence in the family

This is not to suggest that all families presenting with these risk factors will have child victims of sexual abuse, but there is a higher likelihood of child sexual abuse within a family where these risk factors are present than one where they are not.

It has been noted that it is extremely difficult to distinguish between the risk factors for perpetrators within or outside a familial relationship because the majority of studies combine various types of child sexual abuse (Black et al., 2001).

There is disagreement about whether having a history of child sexual abuse is a risk factor for adults who commit sexual abuse against a family member. Smallbone and Wortley (2001) reported that 57% of currently incarcerated intra-familial offenders reported having a history of being a victim of child sexual abuse, whereas other research has found lower rates of offenders reporting being the victim in childhood of sexual abuse.

Extra-familial offending risk factors

The difficulty with categorising risk factors for adult acquaintances or neighbours of the family is that there seems to be only one major risk factor in the perpetrator's background: that they are a biologically unrelated male with access to the child. There is conflicting evidence about whether neglect, substance misuse, low socio-economic status, a history of physical abuse and child sexual abuse, interest in child exploitation material, or violent behaviour are risk factors associated with this cohort of offender.

Risk factors for authority and care relationships

Risk factors for child sexual abuse perpetration in authority and care relationships are relatively broad:

- biologically unrelated male
- young (Sullivan & Beech, 2004, who found that 68% of perpetrators had offended against a child by the age of 21); and
- child sexual abuse history

As the above list illustrates, the risk factors for authority and care offenders is very circumscribed. Unlike other child sexual abuse perpetrators, this limited number of risk factors suggests that screening for child sexual abuse perpetration tendencies in authority and care contexts would be very difficult. The list below includes the variety of risk factors that have been tested for in authority and care offenders, but where research has concluded that they were *not* risk factors:

- psychological deficits;
- traditional gender values;
- interest in child exploitation material;
- computer savvy;
- substance misuse;
- highly sexualised environment;
- social isolation;
- low socio-economic status;
- childhood neglect;
- childhood physical abuse;
- large family size;
- early parenthood;
- prior sexual criminal behaviour;
- prior non-sexual criminal behaviour;
- poor family cohesion; and
- domestic violence in the family.

This cohort of child sexual abuse offender therefore does not exhibit the risk factors that can help easier identification in other relationships and contexts. Without these risk factors these offenders would be difficult to detect by traditional pre-employment screening means (due to their lack of contact with authorities).

Risk factors for female offenders

As mentioned previously, while the number of female child sexual abuse perpetrators is very low, it is useful to point out where female and male adult sexual abuse perpetrators are similar and different. Researchers agree that the following risk factors contribute to a woman

committing child sexual abuse against a child. They may also be risk factors for female professional perpetrators, although female professional perpetrators are more likely to have risk factors relating to their context rather than the more general risk factors for female perpetrators.

The risk factors for females perpetrating child sexual abuse appear to be slightly different to those associated with male perpetrators both within and outside familial relationships. Most interesting is how having a low education and socio-economic status, along with having experienced multiple forms of child abuse, can be risk factors for sexual abuse perpetration in women.

The risk factors for female offending include:

- young (16-25 years)
- low-socio economic status
- low education
- child sexual abuse history
- childhood neglect poor family cohesion; and
- domestic violence in the family

Risk factors for online offenders

Teens involved in sexting or online sexual harassment are not included here.

Risk factors for online offending include:

- biologically unrelated male;
- young (16-25 years)
- interest in child exploitation material
- computer savvy ;
- highly sexualised environment
- social isolation
- violent behaviour

Risk factors for sibling sexual abuse and adolescents with sexually abusive behaviours

Sibling sexual abuse has not been as widely researched as other forms of child sexual abuse; however, the research literature does suggest the following risk factors for youth who sexually abuse siblings:

- young (16-18 years) highly sexualised environment
- childhood neglect
- violent behaviour
- poor family cohesion; and
- domestic violence in the family

There are risk factors that overlap between adolescent and sibling sexual abusers, but there are also risk factors that are unique to the adolescent cohort:

- biologically unrelated male
- young
- interest in child exploitation material
- computer savvy
- highly sexualised environment;
- childhood neglect;
- violent behaviour
- poor family cohesion; and
- domestic violence in the family

Harmful sexual behaviours in children and young people

The following provides an overview of the most recent research on Harmful Sexual Behaviour in children and young people and then provides a link to the assessment framework recently developed by the NSPCC to address this, as well as to the NICE guidance that supports the NSPCC approach.

Research Evidence - *Key messages from research on children and young people who display harmful sexual behaviour - Centre of Expertise on Child Sexual Abuse: Di McNeish and Sara Scott, DMSS Research July 2018*

- The term 'harmful sexual behaviour' (HSB) is used to describe a continuum of sexual behaviours, from inappropriate to problematic to abusive.
- There is a range of common and healthy behaviours at different developmental stages. When a child or young person behaves in ways considered to be outside this range, their behaviour may be called 'harmful' because it is harmful to themselves or others.
- There are no accurate figures on the full spectrum of HSB. However, one major UK study found that two-thirds of contact child sexual abuse was perpetrated by other children and young people.

- The majority of children and young people displaying HSB do not become sexual offenders as adults.
- HSB in pre-adolescent children is more likely to be at the 'inappropriate' or 'problematic' end of the continuum rather than being 'abusive' or 'violent'.
- Young children may be 'acting out' abuse they have experienced themselves, or responding to other trauma and neglect.
- The early teens are the peak time for the occurrence of HSB, most of which is displayed by boys. There are some gender differences, with girls tending to be younger when their HSB is identified.
- Children and young people who display HSB are more likely than other young people to have a history of maltreatment and family difficulties.
- Some children and young people displaying HSB have been sexually abused themselves, but most victims of sexual abuse do not go on to abuse others. It is a history of child maltreatment, rather than sexual abuse specifically, that is most strongly associated with later sexual offending.
- A significant proportion of online-facilitated sex offences are committed by young people, but limited research has been carried out into young people engaging in HSB with an online element. For some young people, there may be a link between viewing online pornography and subsequent HSB.
- There is also limited published research on effective interventions, particularly at the 'problematic' end of the HSB continuum. However, there is a general consensus that interventions need to be holistic and child focused, and involve families.
- Cognitive behavioural-based, multi-systemic and adventure-based interventions have been shown to have benefits for some children.
- Services should avoid stigmatising children and young people as 'mini adult sex offenders'.
- The most effective prevention education takes a 'whole school' approach to healthy relationships, is longer term and involves young people in development and delivery.

What is harmful sexual behaviour?

Sexual behaviours in children and young people can be seen on a continuum ranging from 'normal' and developmentally appropriate, through 'inappropriate' and 'problematic', to 'abusive' and 'violent' (Hackett, 2010) - see the table below. Assessing what is 'normal' behaviour at each developmental stage is not straightforward, and needs to take the social, emotional and cognitive development of the individual child or young person into account. Put simply, however, some behaviours that are normal in young children are concerning if they continue into adolescence; other behaviours, normal in adolescence, would be worrying in younger children (Ryan, 2000; Friedrich et al, 2001; Friedrich et al, 1998). Behaviour outside

the normative range may be called 'harmful', because it is harmful to others or to the child or young person themselves. It may range from activities that are simply inappropriate in a particular context to serious sexual assault (Hackett et al, 2015).

CONTINUUM OF SEXUAL BEHAVIOURS BY CHILDREN AND YOUNG PEOPLE (Hackett, 2010)

Normal	Inappropriate	Problematic	Abusive	Violent
Developmentally expected	Single instance of inappropriate sexual behaviours	Problematic and concerning behaviours	Victimising intent or outcome	Physically violent sexual abuse
Socially acceptable	Socially acceptable	Developmentally unusual and socially unexpected	Includes misuse of power	Highly intrusive
Consensual, mutual, reciprocal	Behaviour within peer group	No overt elements of victimisation	Coercion and force to ensure compliance	Instrumental violence which is physiologically and/or sexually arousing
Shared decision making	Context for behaviour inappropriate	Consent issues may be unclear		
	Generally consensual and reciprocal	May lack reciprocity or equal power	Informed consent lacking, or not able to be freely given by victim	
		May include levels of compulsivity	May include elements of expressive violence	

The extent of harmful sexual behaviour

Accurate figures for the extent of HSB do not exist, not least because HSB covers such a broad spectrum of behaviours, most of which do not come to the attention of the authorities. In one UK study, two-thirds of the contact sexual abuse experienced by children and young people was perpetrated by other young people (Radford et al, 2011), and recent figures show an increase in reports to the police alleging sexual offences committed by young people against other young people (Barnardos, 2017).

What is known about children and young people who display harmful sexual behaviour?

HSB covers a wide range of behaviours, and children and young people identified with HSB are a very diverse group. It is important to avoid generalisations and consider each child as an individual. However, the research highlights some patterns by age, gender and disability (Chaffin et al, 2002).

Pre-adolescent children: While the behaviour of some pre-adolescent children may be 'problematic', it is intentionally abusive in only a small number of cases (Johnson and Doonan, 2005). In these cases, children are likely to have experienced considerable maltreatment from early in their childhoods. Many pre-adolescent children displaying HSB have been sexually abused or exposed to developmentally inappropriate sexual experiences, such as seeing pornography (Johnson, 1988; Chromy, 2007). They may be 'acting out' such experiences as a way of communicating what has happened to them. However, such behaviour can also be an indirect response to other factors in a child's life, including other forms of trauma and neglect (Gray et al, 1999).

Normal sexual behaviours in infancy and early childhood are largely exploratory and are part of children's normal curiosity about their own and other people's bodies. However, pre-adolescent children may display a wide range of problematic sexual behaviours that are beyond what is considered developmentally normal.

Johnson and Doonan (2005) suggest that all of the following criteria should be met for any child aged 11 or under to be defined as 'sexually abusive':

- The child has intentionally touched the sexual organs or other intimate parts of another person, or orchestrates other children into sexual behaviours.

- The child's problematic sexual behaviours have occurred across time and in different situations.
- The child has demonstrated a continuing unwillingness to accept 'no' when pressing another person to engage in sexual activity.
- The child's motivation for engaging in the sexual behaviour is to act out negative emotions toward the person with whom he or she engages in the sexual behaviour, to upset a third person (such as a parent or sibling), or to act out generalised negative emotions using sex.
- The child uses force, fear, physical or emotional intimidation, manipulation, bribery, and/or trickery to coerce another person into sexual behaviour.
- The child's problematic sexual behaviour is unresponsive to consistent adult intervention and supervision.

Adolescents: The vast majority of adolescents who display HSB are male, even taking into account the likelihood that abuse by girls is under-reported (Taylor, 2003; Vizard et al, 2007; Finkelhor, 2009; Hackett et al, 2013). The early teens are the peak time for the occurrence of HSB (Ryan et al, 1996; Taylor, 2003; Hackett et al, 2013). In some cases it is an isolated incident, or is at the problematic rather than the intentionally abusive end of the continuum. Most sexually abusive acts are perpetrated by young people who have other major difficulties in their lives such as prior experience of physical or sexual abuse or neglect, witnessing domestic violence, a lack of positive male role models, or having parents with mental health or substance abuse issues (Salter et al, 2003; Skuse et al, 1998); Glasser et al, 2001); Ogloff et al, 2012). Like other teenagers who get into trouble, they are likely to have low self-esteem, poor social skills and difficulties with anger, depression and peer relationships (Chaffin et al, 2002). HSB may be directed towards younger children, adult women or peers. Compared with those whose HSB targets younger children, adolescents who sexually offend against their peers tend to show higher levels of general delinquency and antisocial behaviours (Parks, 2007; Leversee, 2015; Leibowitz et al, 2016; Fox, 2017). Some peer-on-peer abuse takes place in the context of gangs, where the perpetration of sexual violence can be coerced or become normalised (Firmin with Lloyd, 2017). Most victims of sexual abuse do not go on to abuse others (Salter et al, 2003). Although people who commit sexual offences against children are more likely than other offenders or non-offenders to have been victims of child sexual abuse (Jespersen et al, 2009; Simons et al, 2002), it is a history of child maltreatment - rather than sexual abuse specifically - that is most strongly associated with later sexual offending (Hackett, 2016; Tougas et al, 2016). Most children and young people who display HSB do not go on to sexually offend as adults; if they are arrested later in life, this is likely to be for non-sexual rather than sexual offences (Caldwell, 2002; Chaffin et al, 2002). Those most at risk of further sexual offending are older adolescents who abuse younger children, and children and

young people whose behaviours involve violence (Hackett et al, 2013). Two other factors associated with further sexual offending are general antisocial behaviour and sexually deviant beliefs and impulses (Seto and Lalumière, 2010).

Children and young people with learning disabilities: Children and young people with learning disabilities are more vulnerable both to sexual abuse and to displaying problematic sexual behaviour: in one large UK study, 38% of those referred to specialist services because of HSB were assessed as having a learning disability (Hackett et al, 2013). Such individuals may:

- have less understanding that some sexual behaviours are not acceptable
- receive less sex and relationship education than other young people
- have fewer opportunities to establish acceptable sexual relationships
- struggle with social skills generally
- relate more easily to children younger than themselves.

Girls and young women: Most research is based on male samples, so less is known about HSB in girls and young women. However, research suggests that girls with abusive sexual behaviours have experienced higher levels of sexual victimisation (including intra-familial sexual abuse, other forms of abuse and frequent exposure to family violence) than boys (Mathews et al, 1997; Miccio-Fonseca, 2000; Fromuth and Conn, 1997; Miccio-Fonseca, 2016; Kubik et al, 2003; Masson et al, 2015). In common with their male counterparts, young women who display HSB are often reported to have difficulties in school and to have relatively high levels of learning difficulties (Scott and Telford, 2006; McCartan et al, 2011). HSB tends to be identified at a younger age in girls than in boys, and tends to involve younger victims (Finkelhor et al, 2009); it is less likely to involve penetration or coercion (Allardyce and Yates, 2018). Girls are less likely to be charged with an offence, in part because they and their victims tend to be younger (Hutton and Whyte, 2006; Hickey et al, 2008).

In reviewing the research, Robinson (2009) identifies the following potential pathways for adolescent females who engage in harmful sexual behaviour:

- early maturation - sexualised behaviours for which they are not developmentally prepared, through contact with older males
- depression and victimisation
- family criminality
- poor relationships with parents, particularly mother
- lack of continuity of care
- poor peer networks

- impact of pornography related to their own abusive experiences.

Harmful sexual behaviour and the internet: Research into young people engaging in HSB with an online element is still very limited - and, given the changing context of young people's use of social media, it is a challenge to determine what are developmentally 'normal' and 'problematic' online behaviours (Hackett, 2014). For example, a 2016 UK survey found that 48% of 11-16-year-olds had viewed pornography - and among those who had done so, boys were approximately twice as likely as girls to have actively searched for it (Martellozzo et al, 2016). An earlier US study found that boys were more likely than girls to view more extreme images, more often and at a younger age (Sabina et al, 2008). Studies have estimated that young people commit 3-15% of offences involving CSA imagery, and a similar proportion of offences involving online sexual communication with children (Belton and Hollis, 2016). Some research indicates that young people who view CSA imagery may be different from those who commit other kinds of sexual offences: they may be less likely to have experienced adverse childhood experiences, and more likely to come from stable and economically advantaged family backgrounds and be achieving well educationally (Moultrie, 2006; Stevens et al, 2013; Aebi et al, 2014). There is insufficient evidence to demonstrate that viewing CSA imagery leads to other forms of CSA (Webb et al, 2007; Seto and Eke, 2005; Babchishin et al, 2015), but for some young people there may be a link between viewing online pornography and subsequent behaviour (Beech et al, 2008; Leukfeldt et al, 2014). One UK study found that, among young men displaying both online-facilitated HSB and purely 'offline' HSB, the developmentally inappropriate use of pornography had been a trigger for offline HSB in more than half of cases (Hollis and Belton, 2017).

Effective assessment of children and young people displaying harmful sexual behaviour

There is little published research on the most appropriate ways of assessing children and young people presenting with HSB, although there is general agreement that assessments need to take account of the whole circumstances of the child and their family - including any prior experience of abuse and other behavioural issues (Chaffin et al, 2002; Hackett, 2014). There are a number of tools aiming to assess the likelihood of a child's HSB persisting or escalating, but none has been validated as a predictive measure (Carson, 2017; Prentky et al, 2010). There is general support for the use of holistic assessment tools to help practitioners tailor their support to children and young people. These consider both the specific risks of the young person's behaviour and motivations and their needs and strengths at individual, family and community levels (Hackett, 2014; Prentky et al, 2010; Griffin et al, 2008)

The [NSPCC framework](#) should be used alongside the [NICE guidelines](#) on harmful sexual behaviour among young people, which make recommendations about:

- roles of universal services
- early help assessment and risk assessment
- linking with families pre and post intervention
- key principles and approaches for intervention.

All assessments should be completed using the Child's World format and recorded within the Child's Plan, as set out within the Guernsey Child Care Procedures.

Summary - Common factors associated with perpetration of sexual abuse

Across the various contexts and settings of child sexual abuse, there are similarities in the risk factors to perpetration, as well as similarities in the behaviours engaged in by perpetrators. The common risk factors to perpetration (biologically unrelated male, young, highly sexualised environment, childhood neglect, violent behaviour, poor family cohesion, and domestic violence in the family) can be outside the perpetrator's control; for example, being young, having a history of neglect or being a victim of domestic violence.

However, there are also numerous ambiguous findings from the research regarding other risk factors. There is disagreement between researchers about the following:

- substance misuse;
- low socio-economic status;
- child sexual abuse history;
- childhood physical abuse;
- prior non-sexual criminal behaviour; and
- violent behaviour.

This disparity may be due to differences in the research populations being approached for study. For example, incarcerated males comprise only the known and currently apprehended child sexual abusers and are more likely to be from a low socio-economic status, whereas unapprehended child sexual abuse perpetrators are perhaps more likely to be from a more solid financial background.

Common risk factors, by relationship/context of child sexual abuse offending

Risk factor	Relationship/context
Biologically unrelated male	Familial Authority and care Extra-familial Online Peer
Young	Online Peer Sibling Female
Highly sexualised environment	Familial Online Peer Sibling
Childhood neglect	Female Peer Sibling
Violent behaviour	Online Peer Sibling
Poor family cohesion	Familial Female Peer Sibling
Domestic violence in the family	Familial Female Peer Sibling

Institutional abuse or abuse of those in care settings:

Individuals committing sexual abuse in authority and care relationships do not appear to have the same risk factors to their perpetration as those in other relationships.

To understand how sexual abuse occurs within these settings it is helpful to refer to the work of Marcus Erooga, who identified terms this as a '**corruption of care**' and lists 6 factors which are preconditions within the institution itself - and can be deliberately manipulated by individuals who wish to create an environment where abuse is 'normal' or ignored, drawing in others who would not in other circumstances choose to abuse children in their care:

1. Neutralisation of normal moral concerns: "This suggests that a stage of the process is, effectively, the dehumanisation of the individual: "...they [service users] have to come to be regarded as beyond the normal bounds of moral behaviour which governs relations between person and person or carer and client. They have to be seen as less than fully human". As previously, Finkelhor explains this as part of the pattern of 'distorted thinking' which enables the abuser to minimise the impact of their actions and to view the victim as either willing, or deserving of the abuse, for example.

2. The balance of power and powerlessness: The "corruption of care" is closely connected with the balance of power and powerlessness in organisations. Most of those who suffer abuse in these settings are vulnerable and powerless, either to prevent the abuse occurring, or to report it subsequently, whereas the power and status afforded to teachers, whom both children and parents trust, create the conditions for abuse of that power.

3. Stigmatised activity: "...certain populations....are.... held in less regard by society...." Children from highly deprived backgrounds and with special education needs would come within this definition. One implication, confirmed by research, is that this group of children are more likely to experience abuse, and less likely to be believed when they make allegations. Inadequate training and resources combined with challenging demands in an unusual environment with no adequate support system can lead to stress and isolation. In those circumstances power over children can possibly become a way of gaining a sense of significance for the worker. The children with whom they work, and who may be perceived as part of the source of stress, also become the most available outlet for frustration. Reduced staffing ratios, changes in routine and months at the beginning and end of the school year all had a statistically significant relationship to increases in allegations against staff in 3 studies cited by the author. Finkelhor et al (1988) suggest that much sexual abuse in these settings does not grow out of a specific conscious and pre-existing sexual preference for children of this age. Rather, they suggest that much of the abuse is *opportunistic*, by which they mean

that it has a more general and diffuse motivation than specific sexual attraction, and that the key factor is not the particular sexual attraction but rather the availability and vulnerability of the children.

4. Failures of management: "Management failures underlie the corruption of care, referring to a comprehensive failure in a range of responsibilities by management at every level. Without clear aims and objectives for the organisation, secondary aims become predominant. The efficient operation of the organisation becomes the key concern, at the expense of consideration of the legitimate needs and interests of the individual. Care and rehabilitation become subordinate to priorities of order and control.

5. Closed" organisations: This "corruption of care", it is suggested, is more likely to occur in enclosed, inward-looking organisations. Organisations managed along hierarchical lines can become so highly controlled that it is not possible to challenge their practices. The abuser in this type of organisation is more commonly an authority figure in the institution and protected, albeit unwittingly, by the hierarchical systems in place. Common elements of such organisations can be identified:

- criticism and complaint are easily stifled;
- new ideas are discouraged and rigid and conservative routines and patterns of practice encouraged;
- group norms become so ingrained that to challenge them can be enormously personally and professionally threatening;
- an absence of any external moral or professional challenge to established practice;
- patterns of practice have increasingly low standards and aspirations become those of control, order and the absence of problems.

The distance from this to becoming a "corrupted system" is relatively small.

6. Models of authority: an autocratic officer-in-charge, protected by a strong political and administrative network, with participation in shared decision-making by staff and children discouraged, so giving both a sense of helplessness and powerlessness. The difficulty of managing children is emphasised, with implicit or overt permission to control at any cost, and so ultimately to abuse; a theoretical and ideological model is introduced that tends to "distance, dehumanize and devalue relationships with residents". Other approaches are discouraged or devalued, to increase the status of the preferred method; an "oppressor mentality" that reflects, encourages or tolerates hostility towards females, children or

minorities exists or is encouraged. Within such an environment it becomes more possible for a motivated individual to abuse and to encourage others to do so.

Below you will find some useful links to resources referred to in THE STEPWISE APPROACH and the Care and Support Framework.

With the perpetrator/offender or alleged perpetrator the areas covered in the assessment need to include:

Context of the assessment - explain the reason and purpose of the assessment clearly to all parties. An assessment agreement is helpful that clearly sets out the reason, purpose, areas to be covered and expectations.

Current circumstances – explore the current circumstances including living arrangements, support networks, finances.

Relevant background information - this needs to include any previous child protection concerns, criminal history, childhood experiences, and any other significant events.

Relationship and sexual history - this is a vital part of the process and needs to include all relationships and patterns of behaviour.

Relationship(s) with his children, the abused child and the children's needs – this is particularly helpful when looking at risk where the abused child is not the perpetrator's own child or when internet offences is a factor.

His/her account of the allegations/convictions/sexual abuse - Allow the person to give his/her account in their own words with minimal interruption when they are talking about the abuse. Once they have done this it is important to explore events that led to

Assessment of a perpetrator of child sexual abuse

This can be used where there has been a conviction or allegation.

With the partner/non-abusing parent the assessment focuses on:

Background - this area needs to explore the persons own background, any events or experiences that in particular may increase their vulnerability.

Relationship history - Explore the current relationship with the offender as well as all previous relationships. Consider for any emerging patterns.

Childcare history - It is important to explore the person's parenting history. This might be different for each child if more than one child in the family. Consider attachment in relation to all the children.

Attitude towards the offence and child protection concerns – explore the person's understanding of the offence and what their view of any associated risk may be. It is helpful to ascertain their views on child abuse and ability to recognise signs and indicators of abuse.

Emotional resilience - does the partner have the emotional tools and strength to protect the child. The strain on the person cannot be ignored. Often they are expected to supervise all contact between children and the perpetrator and this can cause additional emotional stress on the family. Their ability to deal with and manage this is crucial as provides insight into their emotional resilience both now and in the future.

Some literature can be dated and not easy to interpret into assessments however '*Child Sexual Abuse and the Internet: Tackling the New Frontier*' by Martin Calder provides a clear focus on the issues and guidance for assessments.

There are also many other publications which can be helpful and the Lucy Faithful Foundation have an extensive reading list.

In relation to internet offending/accessing child abuse images, in addition to the above guidance social work assessments need to:

- Establish if there is any risk of viewing offender becoming a contact offender. This is referred to as "crossover".
- Establish if the offender has used the internet for the purposes of grooming or gaining access to children.

AIM – Sexual Behaviours

Currently there are no local procedures within Guernsey's Children and Family Community Services which embed the use of the AIM assessment framework for children under 12 years or adolescents who display harmful sexual behaviours.

However it is recognised that there remains a need for practitioners within C and FCS to be able to assess harmful sexual behaviours displayed by children and young people. This will enable practitioners to complete thorough and evidence based initial and core assessments, in addition to producing robust care plans which clearly address the needs and risks presented by such children and young people.

In order to achieve this, a number of advanced practitioners have been trained to use both the AIM 2 adolescent and AIM under 12s assessment tools. Both models have been designed to help professionals identify the level of supervision the young person requires to manage risk, but also to outline the therapeutic needs that require addressing, in order to achieve the reduction /cessation of harmful sexual behaviours.

The AIM 2 initial assessment (adolescents) was developed from the original AIM model produced in 2001. The model is designed to assist in early stage assessments of young men who are of mainstream educational ability, aged between 12 and 18 years, who are known to have exhibited harmful sexual behaviour on one or more occasions.

The AIM 2 assessment model is based on four domains:

- harmful behaviours,
- development
- family
- environment

Thus the model links with the Child and Family assessment used in safeguarding children, where focus is on the last three domains and the ASSET tool used within the Youth justice forum, where the focus includes the first domain.

In this way it is intended that the model has relevance to both systems and draws on the skills of the professionals involved in each. (GMAP- pg19:2012) All four domains assess both static and dynamic concern and strength factors.

The under 12's AIM initial and core assessment framework should be used to assess problematic and/or harmful sexual behaviours displayed by children under the age of 12 years. The initial assessment requires practitioners to complete the AIM checklist to determine if the behaviours are healthy, problematic or harmful. Should the behaviours fall in the latter two categories, a core AIM assessment is triggered which involves the completion of a pattern mapping exercise.

Both assessment frameworks continue to be embedded in the process of practitioners using their professional judgement to collect, organise, evaluate and analyse information in order to arrive at an evidenced based assessment and recommendations for the safe and appropriate management of children and young people displaying harmful sexual behaviour. (GMAP: AIM2 manual 2012:4)

Currently, when trained practitioners are allocated to such assessments, it is expected that they will co –assess the case with the allocated social worker but take the lead assessor role. The coordinator for sexually harmful behaviour will offer supervision throughout the process and will quality assure the final assessment report.

The coordinator for sexually harmful behaviour is able to co-assess cases with trained workers if they feel they require a higher level of mentoring in completing their first AIM assessment.

If it is felt an AIM assessment is required, discussion with the locality team manager and then coordinator for sexually harmful behaviour services should be sought in the first instance.

Assessing Vulnerable Adults including Parents with Learning Disabilities

Parenting Assessment Manual (PAMs)

What is it?

The Parent Assessment Manual (PAM) is a comprehensive, assessment tool for use with vulnerable families, including parents with learning disabilities.

PAMS 3.0 is a complete Parent Assessment Application used by Social Workers, Psychologists and other professionals across the UK and abroad. The PAMS assessment was developed by Dr Sue McGaw a nationally renowned Clinical Psychologist in the field of working with parents with learning disabilities) and South Coast Solutions.

The PAMS assessment tool was originally written for parents with Learning Disabilities; it allows all parents to access the system fairly whatever their level of ability.

When working with parents with a Learning Disability practitioners should always refer to the Good Practice Guidance on Working with Parents with a Learning Disability, Department of Health and Department for Education and Skills, 2007 (www.dh.gov.uk/en).

Court reports

As the PAMs assessment process is a recognised report within Court; some Judges are already asking if workers are qualified to complete them, for some cases they can reduce the need for psychological assessments or Independent Social Work assessments which are between £1,500 and £3,500 per report.

However PAMs assessments should not be carried out during court proceedings as they can take a long time and are very much focused upon observations; this can be difficult if children are not in the care of their parents and would have to rely upon observations of contact which is not always appropriate or feasible. The PAMs assessment should be carried out prior to Court proceedings.

There has also been some criticism of the PAMS model as it does not always accurately assess risk and is more focused upon ‘teaching methods’. PAM is not a psychometric test and there are no cut-off criteria for “good enough parenting”. The tool is not a substitute for professional judgement or experience. Other approaches should also be used.

What does it cover?

It covers:

- child care and development
- behaviour management
- independent living skills
- safety and hygiene
- parents’ health
- relationships and support
- and the impact of the environment and community on parenting

Each parenting skill area within a domain is assessed for:

- Parental knowledge
- Quality of parenting skills
- and the frequency of parenting practice

By breaking elements of parenting down into testable components PAMS starts to make an assessment of quality that is evidence-based. After completion, the assessor has a clear visual

family profile of functioning that target parenting support needs, as well as child protection issues.

Based on the Parental Knowledge-Skills-Practice Model the PAM provides professionals with a structured and practical approach to the assessment of parents and their children (0-19 years).

What format is it in?

PAMS 3.0 is an extensive professional software CD-ROM application which includes:

- Clinical Assessment forms
- Worksheets
- Graphical Parent Summary
- Profiles and automatic Report Generation

The PAMs assessment tool is very defined and the worker populates forms and then the report is formatted from this. The report is very quantifiable which means that is not likely to be challenged therefore leading to less delay and clearer outcomes being known for vulnerable children within the city.

PAMS 3.0 has been developed to present information within a format that interfaces well within the Framework for the Assessment of Children in Need and their Families (2000) and the Common Assessment Framework (DfES, 2006).

PAMS 3.0 can be used as a Screening Tool or as a **Comprehensive Specialist Assessment**.

PAMS 3.0 simplifies the measurement of parental capacity and automatically consolidates the assessment data into template reports to assist the assessor with their report writing.

PAMS provides an evidence based assessment which, is intended to reflect more accurately parents knowledge, skills and practice and was developed from twenty years' experience of working with very low functioning parents, many of whom were illiterate and limited in terms of basic life skills.

In addition to the PAMS 3.0 software, a spiral bound Instruction book, knowledge book and parent booklet are included with each pack. The instruction book is an excellent reference and guides the assessor on how to use and apply PAMS 3.0 during and after clinical assessments.

Single Assessment Report and Joint Assessment Report

A Single Assessment Report processes and displays assessment data for one parent. Also, a Joint Assessment Report processes and displays assessment data for two parents.

The reports will include:

Data tables

- Report Summary
- Worksheet Profile
- Worksheet Summaries
- Observation Graph
- Targeted Worksheet Skills

In addition **PAMS Capacity Reports** capture information about a **parent's progress** over time therefore enabling practitioners to accurately assess parents potential for change and therefore inform future planning.